Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

10800

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY: Allegany; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 1.1/4 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 326 Crawford St.

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Lemuel (Last) Arbogast
4. DATE OF DEATH: (Month) Nov. (Day) 23 (Year) 1950
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: April-16-1923
9. AGE Last birthday: 27 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Demurrage Clerk
10b. KIND OF BUSINESS OR INDUSTRY: W.Md.R.Ry.
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: George L. Arbogast
14. MOTHER'S MAIDEN NAME: Mae Cline
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.2
16. SOCIAL SECURITY NO.: 218-16-4246
17. INFORMANT AND ADDRESS: George L. Argogast, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary hemorrhage due to punctured	2.1/2 hr
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) lung, from fractured ribs, left side of chest.	
	(c)	

819.5
1700

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: right ankle fractured

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY * OR CONTRIBUTING * CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Highway Route 36 & 47 near (CITY OR TOWN) Barrellsville (COUNTY) Allegany (STATE) Md.
TIME (Month) (Day) (Year) (Hour) OF INJURY: Nov. 23/50 A. 12.05 m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Auto hit large rock when unable to make a slight curve.

22 *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection* ☐, Inquiry* ☐ therean and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, hamicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.		Cumberland, Md.	Nov. 23-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 25, 1950	Hillcrest Cemetery	Cumberland, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 24, 1950	Winter L. Frantz, M.D.	William S. Light	Cumberland, Md.

26647

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
NOV 28 1950
BUREAU V. A

mw

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

I

T

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

10801

Reg. Dist. No. 1

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN near Old Town
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS in ambulance in route to the Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W.Va. COUNTY Hampshire
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PawPaw
STREET ADDRESS (If rural give location) Okonoko Road.

3. NAME OF DECEASED (Type or Print) (First) Sonja (Middle) L. (Last) Bailey

4. DATE OF DEATH (Month) Nov. (Day) 28 (Year) 1950

5. SEX female

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single

8. DATE OF BIRTH Nov. 1,-1938

9. AGE last birthday 12 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Paw Paw, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Leonard Bailey

14. MOTHER'S MAIDEN NAME Emily Parrill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. ----

17. INFORMANT Father) Leonard Bailey

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hemorrhage from ruptured liver also had 1 hr.

812.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) punctured lung, lower right lobe, from fractured

170c (c) ribs, right side of chest .

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway route #9

near (CITY OR TOWN) Paw Paw (COUNTY) Hampshire (STATE) W.Va.

TIME OF INJURY (Month) (Day) (Year) (Hour) Nov.28/50 3.30 P. m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Sleigh riding, ran under a truck, rear wheel ran over chest.

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Nov.28-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Dec. 1, 1950

NAME OF CEMETERY OR CREMATORY Woodrow Cemetery

LOCATION (City, town, or county) (State) RFD Paw Paw, W. Va.

DATE REC'D BY LOCAL REG. Nov. 29, 1950

REGISTRAR'S SIGNATURE Mrs. Sue C. Ginevan

24. FUNERAL DIRECTOR W. D. Parks, Berkeley Springs, W. Va ADDRESS

RECEIVED
DEC 4 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

10892

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 182 Wineow St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md.
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 182 Wineow St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Annie	Bertha	Bates	Nov.	29	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
female	colored	widow	Jan. 31- 1883	67 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own home	Cumberland, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Robinson	Mary Singleton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	None	Ruth Brown (daughter) 182 Wineow St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion due to	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (420.1 940)	(b) Coronary sclerosis	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.	Cumberland, Md.	Nov. 29-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Dec. 1, 1950	Sumner Cemetery	Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Dec. 1, 1950	Walter K. Mantz, M.D.	John J. Hafer	Cumberland, Md.

RECEIVED
DEC 5 1950
BUREAU V.S

Within corporate limit.

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10803

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 643 HILLTOP DRIVE

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~XXXXXXXXXX~~ CUMBERLAND
STREET ADDRESS 643 HILLTOP DRIVE (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) LOUIS (Middle) (Last) BATIE Jr.
4. DATE OF DEATH (Month) NOV. (Day) 26 (Year) 1950

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH JAN. 20, 1881
9. AGE last birthday 69 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST
10b. KIND OF BUSINESS OR INDUSTRY B&O R.R.
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME LOUIS BATIE
14. MOTHER'S MAIDEN NAME EMMA FUNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY No. 705*05-4799
17. INFORMANT MRS. LOUIS BATIE Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: Very Short time

420.1 94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 27, 1950, to 11-26, 1950, that I last saw the deceased alive on 11-20, 1950, and that death occurred at 2 am m., from the causes and on the date stated above.

SIGNATURE Wm. F. Williams (Degree or title) ADDRESS M.D. Cumberland DATE SIGNED 11-27-50

23. BURIAL, CREMATION REMOVAL (Specify) burial
DATE THEREOF 11/29/50
NAME OF CEMETERY OR CREMATORY Philos Cem.
LOCATION (City, town, or county) wWesternport (State) Md.

DATE REC'D BY LOCAL REG. Nov. 29, 1950
REGISTRAR'S SIGNATURE Wenter R. Frantz, M.D.
24. FUNERAL DIRECTOR E.S. Boal ADDRESS Westernport, Md.

32647

RECEIVED
DEC 5 1950
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

10804

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 9 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany Garrett; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Grantsville; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Etta (Middle) A. (Last) Beachy

4. DATE OF DEATH: (Month) 11 (Day) 14 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Feb. 21/76

9. AGE last birthday: 74 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Somerset County, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: ~~XXXXXXXXX~~ Simon Livengood

14. MOTHER'S MAIDEN NAME: Aminta Cramer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Hospital Record

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of the stomach with metastasis

151X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 46b (b) to the liver. — ?

(c) Died while under anaesthetic

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 11/14/50

19b. MAJOR FINDINGS OF OPERATION: Cancer of stomach

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V. Deming, M.D. H. V. Deming M.D. Cumberland, Md. 11/14/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF Nov. 16 1950 | NAME OF CEMETERY OR CREMATORY Grantsville | LOCATION (City, town, or county) (State) Grantsville Md

DATE REC'D BY LOCAL REG. Nov. 14, 1950 | REGISTRAR'S SIGNATURE Hunter R. Crantz, M.D.

24. FUNERAL DIRECTOR ADDRESS Abe Altenburger Grantsville

RECEIVED
NOV 21 1950
CLEVELAND 1, O.

MARYLAND STATE DEPARTMENT OF HEALTH

10895

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 39 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS Sylvan Retreat

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 114 Primrose Place

3. NAME OF DECEASED (Type or Print): (First) Van; (Middle); (Last) Berry

4. DATE OF DEATH: (Month) Nov. 1, (Day); (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Feb. 9, 1866

9. AGE last birthday: 84 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: C. & A. Gas Co.

11. BIRTHPLACE (State or foreign country): Flintstone, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel K. Berry

14. MOTHER'S MAIDEN NAME: Virginia Eastman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No; (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: N. E. Berry, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocardial failure	1 wk
450.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 97	(b) General arteriosclerosis	4 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION; 19b. MAJOR FINDINGS OF OPERATION; 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify); PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY; (CITY OR TOWN); (COUNTY); (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.; INJURY OCCURRED While at Work ☐ Not While At work ☐; HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1949, to Nov. 1, 1950, that I last saw the deceased alive on Oct. 31, 1950, and that death occurred at 2:15 p.m., from the causes and on the date stated above.

SIGNATURE; (Degree or title); ADDRESS; DATE SIGNED

Arthur F. Jones M. D. 110 S. Centre St. Nov. 2, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: Nov. 3, 1950; NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery; LOCATION (City, town, or county) (State): Flintstone, Md.

DATE REC'D BY LOCAL REG.: Nov. 3, 1950; REGISTRAR'S SIGNATURE: Hunter R. Doty, M.D.

24. FUNERAL DIRECTOR; ADDRESS: William H. Kight, Cumberland, Md.

9359

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 7 1950
BUREAU U. S.

10896

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 9 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gilmore
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Jacob (Middle) Nelson (Last) Blubaugh

4. DATE OF DEATH (Month) November (Day) 28 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Mar 27, 1894
9. AGE last birthday 56 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner
10b. KIND OF BUSINESS OR INDUSTRY Coal Mine
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Blubaugh
14. MOTHER'S MAIDEN NAME Eleanor Thrasher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 217-05-7166
17. INFORMANT Irvin Blubaugh

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) ventricular fibrillation	1 hour
416X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) congestive heart failure	2 months
95b	(c) rheumatic heart disease	25 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-14, 1950, to 11-28, 1950, that I last saw the deceased alive on 11-27, 1950, and that death occurred at 11 a.m., from the causes and on the date stated above.

SIGNATURE Ludolph Wolfermann (Degree or title) M.D. ADDRESS Frostburg, Md. DATE SIGNED 11-30-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Dec 1, 1950
NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery
LOCATION (City, town, or county) Lonaconing (State) Md

DATE REC'D BY LOCAL REG. 11-30-50
REGISTRAR'S SIGNATURE Mrs Nancy H. Roe
24. FUNERAL DIRECTOR M.Eichhorn ADDRESS Lonaconing, Md.

45402

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 4 1950

Within corporate limits

DR. WEISMAN

10807

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.
LENGTH OF STAY (in this place) 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CORRIGANSVILLE
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) CARL (Middle) R (Last) BOORE

4. DATE OF DEATH (Month) NOV. (Day) 10 (Year) 1950

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH JUNE 3, 1903
9. AGE last birthday 47 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker
10b. KIND OF BUSINESS OR INDUSTRY Strip Mining
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME NORVAL BOORE
14. MOTHER'S MAIDEN NAME GLADYS DICKEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 214-07-1711
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pulmonary embolus	48 hours
410X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Left ventricular Myocardial Failure	72 hours
92b	(c) Inactive Rheumatic Heart Disease with mitral valve deformity	40 years

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pleural Effusion — unknown

19a. DATE OF OPERATION No
19b. MAJOR FINDINGS OF OPERATION No
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) No (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) No m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? No

22. I hereby certify that I attended the deceased from Winter, 1948, to Nov 10, 1950, that I last saw the deceased alive on Nov 10, 1950, and that death occurred at 11:05 a.m., from the causes and on the date stated above.

SIGNATURE Saville G. Weisman (Degree or title) Mrs ADDRESS 59 Greene St Cumberland, Md DATE SIGNED 11/11/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov. 13, 1950
NAME OF CEMETERY OR CREMATORY Greenmount
LOCATION (City, town, or county) Cumberland, Md. (State)

DATE REC'D BY LOCAL REG. Nov. 11, 1950
REGISTRAR'S SIGNATURE Winter R. Trontz, M.D.
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 14 1950
BUREAU V. R

Dr. Bowing

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10898

CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cresaptown
MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cresaptown
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) Greaser (Last) Borgman

4. DATE OF DEATH: (Month) Nov. (Day) 14, (Year) 19 50

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 11-6-1883

9. AGE last birthday: 67 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Preston Co. W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry L. Greaser

14. MOTHER'S MAIDEN NAME: Louise Russell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-18-1089

17. INFORMANT AND ADDRESS: Edward Borgman Cresaptown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

170 x

Immediate cause (a) Carcinoma of Breast — Interval Between Onset and Death: 3 Mos.

50

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-1- 19 50, to 11-19 19 50, that I last saw the deceased alive on 11-14, 19 50, and that death occurred at 2 30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

C. M. Bowing M.D. 57 Green St. 11-16-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 11-18-1950
NAME OF CEMETERY OR CREMATORY: St. Ambrose Cem.
LOCATION (City, town, or county) (State): Cresaptown, Md.

DATE REC'D BY LOCAL REG.: Nov. 16, 1950
REGISTRAR'S SIGNATURE: M. L. Dennis

24. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 5 1951
USAU V. S

Within corporate limits

Dr. Everhart

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

16809

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 501 Patterson Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
STREET ADDRESS (If rural, give location) 501 Patterson Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ella	Catherine	Boston	Nov.	12,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Single	3-9-1876	74 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Elevator operator	U.S. Gov't	Lonaconing, Md.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Adam E. Boston	Mary Hilderbrandt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Mrs. James Morris Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	10 days
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chr myocarditis	√ yrs
93d	(c) Hypertention	" "
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—	—	—	—

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
— m.	—	—

22. I hereby certify that I attended the deceased from 194√, 19....., to Nov 12, 19√0, that I last saw the deceased alive on Nov 12, 19√0, and that death occurred at 8:00 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Hyde R. Everhart MD 36 Greene St Cumberland Md 11/13/√0

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11-15-1950	St. Lukes Cem.	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 15, 1950	Walter P. Krantz M.D.	Charles L. George	Cumberland, Md.

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Dr. McLane
10810

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH- COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Stoyer Street	STREET ADDRESS (If rural, give location): Stoyer Street

3. NAME OF DECEASED (Type or Print)	(First) MARY	(Middle) (SCOTT)	(Last) BROWN	4. DATE OF DEATH	(Month) Nov. (Day) 24, (Year) 1950
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed	8. DATE OF BIRTH: 11-11-1871	9. AGE last birthday: 79 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife	10b. KIND OF BUSINESS OR INDUSTRY: home	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: Adam Scott	14. MOTHER'S MAIDEN NAME: Jane Nicols				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: none	17. INFORMANT AND ADDRESS: Mrs. James Bond, Frostburg, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chr Myocarditis — 6 mo

422.1 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio Sclerosis — years

93d (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1949, 19....., to Nov 24, 1950, that I last saw the deceased alive on Oct 13, 1950, and that death occurred at 4:30 P m., from the causes and on the date stated above.

SIGNATURE: WOM Lane MD (Degree or title) ADDRESS: Frostburg Md DATE SIGNED: 11-25-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 11-27-50	NAME OF CEMETERY OR CREMATORY: Vale Summit Cemetery	LOCATION (City, town, or county) (State): Vale Summit, Md.
DATE REC'D BY LOCAL REG. 11-27-50	REGISTRAR'S SIGNATURE: Mrs. Nancy H. Roe	24. FUNERAL DIRECTOR: J. R. Durst, Frostburg, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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Within corporate limits

Mrs ME Byrd

10811

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place) 2 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pinto
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital	STREET ADDRESS (If rural, give location) Rt. 5, Cumberland, Md.

3. NAME OF DECEASED (Type or Print)	(First) Mary	(Middle) Ellen	(Last) Byrd	4. DATE OF DEATH	(Month) Nov (Day) 26 (Year) 1950
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Oct 4, 1883	9. AGE last birthday 67 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Keyser, W. Va.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Henry Neff	14. MOTHER'S MAIDEN NAME Zipporah E. McKenzie				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT Frank L. Byrd, Rt. 5, Cumberland, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) cancer of the pancreas	6 months
157X Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
46g	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-4-, 1950, to 11-26-, 1950, that I last saw the deceased alive on 11-26-, 1950, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
L Winnings	MD	57 Greene St.	~~11-26~~ 11-26-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Nov 29, 1950	NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	LOCATION (City, town, or county) Cumberland, (State) Md.
DATE REC'D BY LOCAL REG. Nov. 29, 1950	REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR John J. Hofer, Cumberland, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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Within corporate limits

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10812

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) C. (Last) Byrnes

4. DATE OF DEATH (Month) Nov. (Day) 22 (Year) 1950

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH Oct 16-1898

9. AGE last birthday 52 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John J. Byrnes

14. MOTHER'S MAIDEN NAME Elizabeth Sullivan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS Eleanor C Byrnes

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bronchial Pneumonia	10 days
491X Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
107	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Rheumatoid arthritis, chronic	2 years

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 18 m., 1949, to ....., 19....., that I last saw the deceased alive on 22 nov., 1950, and that death occurred at 8 45 p m., from the causes and on the date stated above.

SIGNATURE W. Alfred Von Oemer (Degree or title) ADDRESS Cumberland Md. DATE SIGNED 24 nov. 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE 11-25-50

NAME OF CEMETERY OR CREMATORY St. Michaels

LOCATION (City, town, or county) (State) Frostburg Md.

DATE REC'D BY LOCAL REG. Nov. 24, 1950

REGISTRAR'S SIGNATURE Winter R. Frantz M.D.

24. FUNERAL DIRECTOR J. R. Durst, ADDRESS Frostburg, Md

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Within corporate limits

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.
LENGTH OF STAY (in this place) 16 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA COUNTY Grant
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PETERSBURG
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) JOHN (Middle) ROY (Last) CARTER

4. DATE OF DEATH (Month) NOV. (Day) 18 (Year) 1950

5. SEX MALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED

8. DATE OF BIRTH SEPT. 14, 1883

9. AGE last birthday 67 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Conductor

10b. KIND OF BUSINESS OR INDUSTRY R.R. Co.

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME HILL CARTER

14. MOTHER'S MAIDEN NAME ANNIE WILLIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial, failure	Instant.
155X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma gall bladder with obstruction of duodenum	3 wks
46f	(c) Arteriosclerotic heart disease with heart block	unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Nov 18, 1950

19b. MAJOR FINDINGS OF OPERATION Carcinoma gall bladder obstructing duodenum

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 14, 1950, to Nov 18, 1950, that I last saw the deceased alive on Nov 18, 1950, and that death occurred at 11 30 A m., from the causes and on the date stated above.

SIGNATURE Wylie M Faw Jr (Degree or title) M.D. ADDRESS Cumberland Md. DATE SIGNED Nov 18, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 11/20/50

NAME OF CEMETERY OR CREMATORY Maple Hill

LOCATION (City, town, or county) (State) Petersburg Grant W Va

DATE REC'D BY LOCAL REG. Nov 18, 1950

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR P. E. Thrush & Son ADDRESS Petersburg, W. Va. 10247

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 21 1950
BUREAU V. S

DR. HODGES

10814

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE PENNSYLVANIA COUNTY BEDFORD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 3 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BEDFORD
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) BABY (Middle) BOY (Last) CLARK				4. DATE OF DEATH (Month) NOV. (Day) ~~2~~ 3 (Year) 1950	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH OCT. 30.	9. AGE last birthday yrs.	If under 1 year Months / Days 3 — If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME VAUGHN N. CLARK			14. MOTHER'S MAIDEN NAME NAOMI W. WARD		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL -CUMBERLAND, MD.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

762.0 Immediate cause (a) Bilateral Pulmonary Atelectasis

160C Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Aspiration Mucus + Stomach contents

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on 3 Nov, 1950, and that death occurred at 11:30 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Fuller B. Whitworth M.D. 112 Bedford St. Cumb Md 3 Nov 50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Nov. 4, 1950	NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery	LOCATION (City, town, or county) Breezewood (State) Pa.
DATE REC'D BY LOCAL REG. Nov. 3, 1950	REGISTRAR'S SIGNATURE Hunter R. Crantz, M.D.	24. FUNERAL DIRECTOR Louis Geisel	ADDRESS Bedford, Pa

200 300 291 407

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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NOV 17 1950
BUREAU V. S

10815

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

M

I

VS. A15

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Luke
LENGTH OF STAY (in this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS 221 Fairview Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Luke
STREET ADDRESS (If rural, give location) 221 Fairview Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Clarence	Estin	Clark	Nov.	21,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	White	Widower	Oct. 15, 1877	73 yrs.	1	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic - Retired	W.Va. Pulp & Paper	Grant Co., W. Va.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jacob Clark	Mary Riggleman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
	?	Moses W. Clark, Luke, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis and Myocardial Degeneration Not Specified as Rheumatic	2 Years
Antecedent cause(s) 422.1 93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	5 Years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
None				

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

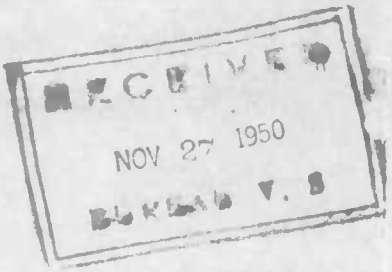
22. I hereby certify that I attended the deceased from Sept 10, 1949, to Nov. 21, 1950, that I last saw the deceased alive on Nov. 20, 1950, and that death occurred at 2:40 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Paul R. Wilson	M.D.	Piedmont W. Va.	Nov. 23, 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11-24-50	Waxler Cemetery	Allegany Co. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11/24/50	G. Braynbaker M.D.	Rogers Funeral Home	Keyser, W. Va.

336-11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10815

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 13 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): Rt. 3 - Bowman's Addt.

3. NAME OF DECEASED (Type or Print): (First) Richard (Middle) Gerald (Last) Collins

4. DATE OF DEATH: (Month) Nov (Day) 2 (Year) 1950

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: July 29, 1923

9. AGE last birthday: 27 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electric Welder

10b. KIND OF BUSINESS OR INDUSTRY: Pittsburgh Pipe & Equip. Co.

11. BIRTHPLACE (State or foreign country): Chaneysville, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: McKinley Collins

14. MOTHER'S MAIDEN NAME: Virginia A. Perrin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-14-6145

17. INFORMANT AND ADDRESS: Virginia Collins, Rt. 3, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pneumonia, lobar bilateral	3 weeks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) II Diabetes mellitus	?
	(c) II Uremia	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 31, 1950, to Nov 2, 1950, that I last saw the deceased alive on Nov 2, 1950, and that death occurred at 11:00 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George M Simon M.D. 128 Union St Cumberland Md. 11/3/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Nov. 5, 1950

NAME OF CEMETERY OR CREMATORY: Mt. Zion Christian Cemetery

LOCATION (City, town, or county) (State): Chaneysville Pa.

DATE REC'D BY LOCAL REG.: Nov. 4, 1950

REGISTRAR'S SIGNATURE: Hunter R Dantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: John J. Hofer, Cumberland, Md.

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BUREAU V. S.

Dr. Moseley

10817

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Main St.,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
STREET ADDRESS (If rural, give location): Main St.,

3. NAME OF DECEASED (Type or Print): (First) CATHERINE (Middle) (Last) CONWAY

4. DATE OF DEATH: (Month) Nov. (Day) 14, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: Apr. 30, 1883

9. AGE last birthday: 67 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Mt. Savage, Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Peter Conway

14. MOTHER'S MAIDEN NAME: Jane Barrett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Mrs. Margaret Collins Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Carcinoma Lower Jaw	3 years.
196X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	about 2 years
45d	(c) Chronic Nephritis & Edema	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1950, to November, 1950, that I last saw the deceased alive on Nov. 14, 1950, and that death occurred at 5:50 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
William E. Moseley | Mt. Savage Md. | November 16-1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Nov. 17, 1950 | NAME OF CEMETERY OR CREMATORY: St. Patricks | LOCATION (City, town, or county) (State): Mt. Savage, Md.

DATE REC'D BY LOCAL REG.: Nov. 16, 1950 | REGISTRAR'S SIGNATURE: Veronica McDermitt

24. FUNERAL DIRECTOR: H. Wayne George | ADDRESS: Cumberland, Md.

52096

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 24 1950
BUREAU OF S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

10818

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 405 N.Center St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md.
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 405 N.Center St.

3. NAME OF DECEASED (Type or Print): (First) Daniel (Middle) (Last) Couthard

4. DATE OF DEATH: (Month) Nov. (Day) 29 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single

8. DATE OF BIRTH: April-17-1881

9. AGE last birthday: 69 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: Odd jobs.

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Couthard

14. MOTHER'S MAIDEN NAME: Nancy Lyeberger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-12-8963

17. INFORMANT: Charles Couthard (brother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Chronic myocarditis	about 2 yrs.
	(c)		

420.1
932

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☐, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title): H.V.Deming M.D. H. V. Deming M.D.
ADDRESS: Cumberland, Md.
DATE SIGNED: Nov.29-1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Dec. 2, 1950
NAME OF CEMETERY OR CREMATORY: St. Patrick Cemetery
LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: DEC. 1, 1950
REGISTRAR'S SIGNATURE: Lester R. Hartz, M.D.

24. FUNERAL DIRECTOR: Louis Stein Inc.
ADDRESS: Cumberland, Md.

74099

VS. A15A

RECEIVED
DEC 5 1950
BUREAU T. S.

Dr. P.E. Berry

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
LENGTH OF STAY (In this place) 67 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 78 Main Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) 78 Main Street

3. NAME OF DECEASED (Type or Print): (First) MICHAEL (Middle) THOMAS (Last) DAILEY

4. DATE OF DEATH: (Month) Nov. (Day) 3 (Year) 19 50

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 3 / 1885

9. AGE last birthday: 65 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner of trucking Co.

10b. KIND OF BUSINESS OR INDUSTRY: Trucking

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: MICHAEL JOSEPH DAILEY

14. MOTHER'S MAIDEN NAME: MARY LOUISE MORGAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO.

17. INFORMANT: MRS. THOMAS DAILEY

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	1 Day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Duodenal Ulcer	25 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Sept 25, 1950, to Nov. 3, 1950, that I last saw the deceased alive on Nov. 2, 1950, and that death occurred at 6 p.m. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
P.E. Berry	M.D.	Piedmont W.Va	11/4/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11/6/50	Philos Cemetery	Westernport Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11/4/50	G. Baysinger M.D.	E.S. Boal	111 Church St. Westernport Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 7 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

10820

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland | LENGTH OF STAY (in this place) Unknown
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE ~~Maryland~~ Pennsylvania COUNTY ~~Allegany~~
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Cumberland~~ Donora Pa.
STREET ADDRESS ~~Donora, Pa.~~ (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Camillo (Middle) (Last) D'Atri
4. DATE OF DEATH: (Month) 11/13/50 (Day) (Year) 19

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)
8. DATE OF BIRTH: 6/4/1888
9. AGE last birthday: 62 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Furnace Worker
10b. KIND OF BUSINESS OR INDUSTRY: Steel Mill
11. BIRTHPLACE (State or foreign country): Crecchio Italy
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francesco D'Atri
14. MOTHER'S MAIDEN NAME: Gulia D'Allesandro

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Wife

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary sclerosis — 2 yr.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
420.1 9th
(b) Coronary insufficiency
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/5, 19 50, to 11/13, 19 50, that I last saw the deceased alive on 11/12, 19 50, and that death occurred at 9 05 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Elizabeth Arbuge, M.D. | 55 Greene St. | 11/13/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 11/17/50 | NAME OF CEMETERY OR CREMATORY: Calvary Cemetery | LOCATION (City, town, or county) (State): Pittsburg, Pa.

DATE REC'D BY LOCAL REG.: Nov. 14, 1950 | REGISTRAR'S SIGNATURE: Hunter R Crantz, M.D.
24. FUNERAL DIRECTOR: James F. Scarpelli | ADDRESS: Cumberland, Md

11624

RECEIVED
NOV 21 1950
BUREAU V. S

Within corporate limits

BIRTH YEAR AND AGE: Dr. Jacobson's letter filmed 1-26-51 G130 L

10821

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Md. LENGTH OF STAY (in this place) 26 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural, give location) 872 Maryland, Ave.

3. NAME OF DECEASED (Type or Print) (First) Ernest (Middle) E (Last) Davis
4. DATE OF DEATH (Month) 11 (Day) 29 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH July 23, 1891
9. AGE last birthday 59 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouse Supervisor
10b. KIND OF BUSINESS OR INDUSTRY Wholesale Liquor
11. BIRTHPLACE (State or foreign country) Martinburg, W Va.
12. CITIZEN OF WHAT COUNTRY? U.S. A.
13. FATHER'S NAME Charles Davis
14. MOTHER'S MAIDEN NAME Mary E. Fellers
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) W W 1
16. SOCIAL SECURITY No. 214-05-6489
17. INFORMANT Veronica L Davis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Severe Myocardial disease & Myocardial Decomp. 6 days.

420.1 Antecedent cause(s) Cerebrovascular Accident (Embolus) 6 days.

93e Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Left side & paralysis Enter right side

(c) Coronary Artery Disease ?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Myocardial disease. ? 11/27/50.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION Arterial Embolus Left Femoral
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 6, 1947, to Nov. 29, 1950, that I last saw the deceased alive on Nov 29, 1950, and that death occurred at 10 15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Jennie Jacobson Hero ADDRESS 50 Bishop St DATE SIGNED 12/1/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 12/3/50 NAME OF CEMETERY OR CREMATORY St. Peters & Pauls LOCATION (City, town, or county) Cumberland Md. (State)

DATE REC'D BY LOCAL REG. Dec. 2, 1950 REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland Md

31660

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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DEC 5 1950
BUREAU V. S.

Within corporate limits

Dr. Burnett,

10822

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS 322 Grand Ave.	STREET ADDRESS (If rural, give location) 322 Grand Ave.

3. NAME OF DECEASED (Type or Print)	(First) Mary	(Middle) Catherine	(Last) Davis	4. DATE OF DEATH	(Month) Nov. (Day) 26, (Year) 1950
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 11-1-1854	9. AGE last birthday 96 yrs.	If under 1 year Months / Days; If under 24 hrs. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Morgantown, W. Va.	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Noah Calvert	14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Mrs. Carl Ritter Cumberland, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uraemia	3 wks.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	20 yrs
	(c)	

450.0

97

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Nov. 24, 1950, to Nov. 26, 1950, that I last saw the deceased alive on Nov. 24, 1950, and that death occurred at 3 a. m., from the causes and on the date stated above.

SIGNATURE Clay E. Burrett (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED 11/27/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 11-28-1950	NAME OF CEMETERY OR CREMATORY Mt. Union Cem.	LOCATION (City, town, or county) (State) Near Morgantown W. Va.
DATE REC'D BY LOCAL REG. Nov. 27, 1950	REGISTRAR'S SIGNATURE Winter L. Frantz, M.D.	24. FUNERAL DIRECTOR Charles L. George	ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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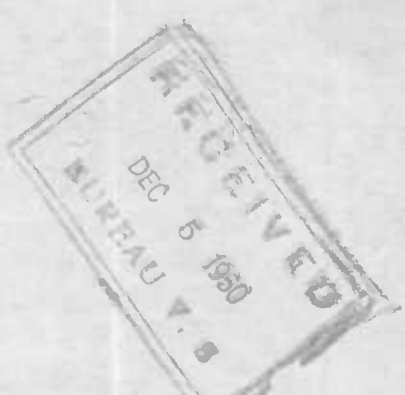
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DEC 5 1950
BUREAU

Within corporate limits

10823

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.
LENGTH OF STAY (in this place) 4 HOURS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY GARRETT
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN DEER PARK, Rural
STREET ADDRESS (If rural, give location) near Deer Park

3. NAME OF DECEASED (Type or Print) (First) LINNA (Middle) L. (Last) DeWITT

4. DATE OF DEATH (Month) NOV. (Day) 8 (Year) 1950

5. SEX MALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH OCT. 9, 1888

9. AGE last birthday 62 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Preacher & Farmer

10b. KIND OF BUSINESS OR INDUSTRY Own

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ABEL DeWITT

14. MOTHER'S MAIDEN NAME CARRIE JOSEPHINE SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-16-5558

17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary sclerosis	6 mos.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Acute cholecystitis	3 days
	(c)	

420.1

94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-8-, 1950, to 11-8-, 1950 that I last saw the deceased alive on NOV. 8, 1950, and that death occurred at 2:25 P.m., from the causes and on the date stated above.

SIGNATURE D. Bloome M.D. (Degree or title) ADDRESS CUMBERLAND, MD. DATE SIGNED NOV. 8, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Nov-11-1950

NAME OF CEMETERY OR CREMATORY Deer Park

LOCATION (City, town, or county) (State) Deer Park Md

DATE REC'D BY LOCAL REG. Nov. 10, 1950

REGISTRAR'S SIGNATURE Winter R. Frantz, MD

24. FUNERAL DIRECTOR Emroy Bolden ADDRESS Oakland, Md

000 11

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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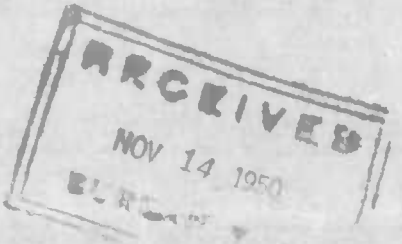
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NOV 14 1950

Within corporate limits

DW. WHITWORTH

10824

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD
LENGTH OF STAY (in this place) 3 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near CUMBERLAND, [redacted] Rural
STREET ADDRESS (If rural, give location) POTOMAC PARK, Rt. #6

3. NAME OF DECEASED (Type or Print) (First) DON (Middle) BRUCE (Last) DIEHL
4. DATE OF DEATH (Month) NOV. (Day) 15 (Year) 1950

6. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE
8. DATE OF BIRTH 9-23-50
9. AGE last birthday yrs. If under 1 year Months 7 Days 5 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY Infant
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME HARRY B. DIEHL
14. MOTHER'S MAIDEN NAME ANNIE RUSSELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Shock - Post - Operative

561.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Strangulated Rt Inguinal Hernia

122a (c) = Gangrene terminal Ileum

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 13 Nov 50
19b. MAJOR FINDINGS OF OPERATION Gangrene + perforation terminal ileum
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on 15 Nov, 1950, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Fuller B. Whitworth MD

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov 17/50
NAME OF CEMETERY OR CREMATORY Madley Cemetery
LOCATION (City, town, or county) (State) Madley, Pa.

DATE REC'D BY LOCAL REG. Nov. 17, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR William H. Kight ADDRESS Cumberland, Md.

209230 252 407

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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NOV 21 1950
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

10825

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany | MARYLAND | LENGTH OF STAY (in this place)
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland rural
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Potomac river at Spring Gap

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. | COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): Canal St.

3. NAME OF DECEASED (Type or Print): (First) George (Middle) (Last) Eaton

4. DATE OF DEATH: (Month) Nov. (Day) 4 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Aug. 18 1918

9. AGE last birthday: 32 yrs. | If under 1 year: Months | Days | If under 24 hrs: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Eaton

14. MOTHER'S MAIDEN NAME: Victoria E. Couthard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mrs. Roy Litten, Ridgley, W.Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
929.8 Immediate cause	(a) Asphyxia due to drowning	a few minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 183	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Body found on island, near Spring Gap, Md. Dec. 10/5

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OR office bldg., etc.) INJURY Potomac River near | (CITY OR TOWN) Cumberland | (COUNTY) Allegany | (STATE) Md.

TIME (Month) (Day) (Year) OF INJURY Nov. 4/50 | (Hour) 11 P. m. | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? Walking over W.Md R. Ry. bridge and fell into Potomac river

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H. V. Deming M.D.		Cumberland, Md.	Dec. 11-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	12-12-50	Rose Hill	Cumberland	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Dec. 12, 1950	Walter K. Frantz M.D.	Louis Steitz Inc.	Cumberland, Md.

XVX99

DEC 20 1990
BUREAU

Dr Diehl
10826

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH- COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Md. COUNTY: Alleg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miner's Hospital	STREET ADDRESS (If rural, give location): 31 Hill St.

3. NAME OF DECEASED (Type or Print): (First) David (Middle) (Baby) Laird (Last) Fearer

4. DATE OF DEATH: (Month) Nov. (Day) 7 (Year) 1950

Sex: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: Nov. 4th, 1950.

9. AGE last birthday: yrs. If under 1 year: Months. Days 3 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Clifford P. Fearer

14. MOTHER'S MAIDEN NAME: Willa Delaney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Clifford P. Fearer, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Premature birth	3 days.
776X Antecedent cause(s)		
159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-4, 1950, to 11-7, 1950, that I last saw the deceased alive on 11-7, 1950, and that death occurred at 3:50 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): H. C. Diehl, M.D. — ADDRESS: Frostburg, Md. — DATE SIGNED: 11-7-50.

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 11/8/50 — NAME OF CEMETERY OR CREMATORY: St. Michael's Cemetery — LOCATION (City, town, or county): Frostburg, (State) Md.

DATE REC'D BY LOCAL REG.: 11-8-50 — REGISTRAR'S SIGNATURE: Mrs. Nancy H. Roe

24. FUNERAL DIRECTOR: Joseph R. Durst, Frostburg, Md. — ADDRESS

20X040323302

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 11 1950
BUREAU V. S.

Within corporate limits

10827

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place) 51 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 184 Winsow St

3. NAME OF DECEASED (Type or Print) (First) Genevieve (Middle) Washington (Last) Fegna
4. DATE OF DEATH (Month) Nov (Day) 26 (Year) 1950
5. SEX Female
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Nov 23 1899
9. AGE last birthday 51 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Cumberland Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Hall
14. MOTHER'S MAIDEN NAME Bessie Weeden
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) —
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs Thomas Taylor, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) peritonitis	7 days
561.2 Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) strangulated umbilical hernia	8 days
122a	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 11-19-50
19b. MAJOR FINDINGS OF OPERATION gangrenous piece of transverse colon
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-19-, 1950, to 11-26, 1950, that I last saw the deceased alive on 11-26-, 1950, and that death occurred at 6:30 A m., from the causes and on the date stated above.

SIGNATURE Wrings (Degree or title) MD ADDRESS 57 Greene St. DATE SIGNED 11-26-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Nov 29 50
NAME OF CEMETERY OR CREMATORY Rose Hill Cem
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Nov. 28, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS " " "

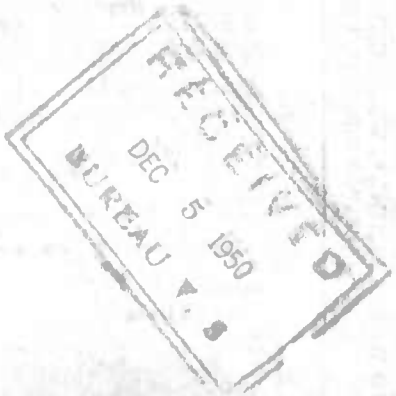
52086

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

L. Berg



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

16828

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; MARYLAND; LENGTH OF STAY (in this place) 45 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 108 S. Centre St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 108 S. Centre St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John	Aubrey	Findlay	Nov.	9	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	July 11 1886	64 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Traveling Freight Agent	Railway	Ft Wayne, Ind	U.S.A.

13. FATHER'S NAME: James Findlay

14. MOTHER'S MAIDEN NAME: Rosiam Reed

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 219-03-9050

17. INFORMANT AND ADDRESS: Marguerite Twigg Findlay Cumb'd Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uremia	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Myelogenous Leukemia	?
	(c)	

204.1
74a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Nov. 20, 1950, to Nov. 9, 1950 that I last saw the deceased alive on Nov. 9, 1950 and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE W. K. Williams (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED 11-10-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Nov 12 1950	Rose Hill Cem.	Cumberland,	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 11 1950	Hunter R Trantz, M.D.	Lowe Stein, Inc	Cumberland Md.

26647

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 14 1950
BUREAU V. R

Within corporate limits

Dr. Elizabeth Brings

10829

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 21 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print) (First) Louis (Middle) E. McComas (Last) George

4. DATE OF DEATH (Month) Nov (Day) 8 (Year) 1950

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH May 9, 1889

9. AGE last birthday 61 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter

10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.

11. BIRTHPLACE (State or foreign country) Swanton, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Frederick George

14. MOTHER'S MAIDEN NAME Mary E. Brady

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-07-6845

17. INFORMANT AND ADDRESS Mrs. Hannah B. George, Rt. 1, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) peripheral embolism - gangrene of leg	5 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) coronary occlusion	3 weeks
	(c) coronary sclerosis	3 yrs.

420.1

94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1947, to Nov. 8, 1950, that I last saw the deceased alive on Nov. 8, 1950, and that death occurred at 6 P m., from the causes and on the date stated above.

SIGNATURE Elizabeth Brings (Degree or title) ADDRESS 55 Greene St. Cumberland DATE SIGNED 11/1/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Nov. 11, 1950

NAME OF CEMETERY OR CREMATORY George Cemetery

LOCATION (City, town, or county) Swanton (State) Md.

DATE REC'D BY LOCAL REG. Nov. 11, 1950

REGISTRAR'S SIGNATURE Winter R Trantz, M.D.

24. FUNERAL DIRECTOR John J. Hafer, Cumberland, ADDRESS Md.

348 16

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
NOV 14 1950
BUREAU

MEBRINGS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

16830

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
LENGTH OF STAY (In this place) 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 118 Kalbaugh St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location) 118 Kalabugh St.,

3. NAME OF DECEASED (Type or Print): (First) Myrtle (Middle) Ellen (Last) Gerstell
4. DATE OF DEATH: (Month) Nov. (Day) 1, (Year) 1950

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: Sept. 5, 1896
9. AGE last birthday: 54 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Beverly, W.Va.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Robert Masteller
14. MOTHER'S MAIDEN NAME: Lucretia Sharpless

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Rev. Joseph E. Gerstell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Nephritis	2 mo.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension Cardio-Vascular Disease	2 yrs
4434 / 932	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 1, 1950, to Nov. 1, 1950, that I last saw the deceased alive on Nov. 1, 1950, and that death occurred at 6:45 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
F. E. Berry	M. D.	Piedmont W. Va	10/3/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11/4/50	Philos Cem.	Westernport, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11/4/50	[signature]	B. W. Markwood	Keyser, W. Va.

RECEIVED
NOV 7 1950
BUREAU V. S

Outside of City Limits

10831

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Near Cumberland, Rural — LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: R. D. #1 Crystal Park

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Near Cumberland, Rural

STREET ADDRESS (If rural, give location): R. D. #1 Crystal Park

3. NAME OF DECEASED (Type or Print): (First) REBECCA (Middle) ELIZABETH (Last) GRAHAME

4. DATE OF DEATH: (Month) Nov. (Day) 30, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Feb. 20, 1869

9. AGE last birthday: 81 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Domestic Own Home

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Thomas Grahame

14. MOTHER'S MAIDEN NAME: Anna Duke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Mrs. Faye Keiser R. D. #1 Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hypertensive Heart Disease	Second year
252.0 Antecedent cause(s)	(b) Chr. Nephritis	seven years
63b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Hyperthyroidism	20 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Uraemia	3 mos

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1920, 19....., to Nov 30, 1950, that I last saw the deceased alive on Nov 28, 1950, and that death occurred at 4.30 a m., from the causes and on the date stated above.

SIGNATURE: F. Alan G. Murray M.D. (Degree or title) — ADDRESS: Cumberland Md — DATE SIGNED: Dec 1-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Dec. 2, 1950 — NAME OF CEMETERY OR CREMATORY: St. Patricks — LOCATION (City, town, or county) (State): Mt. Savage, Maryland

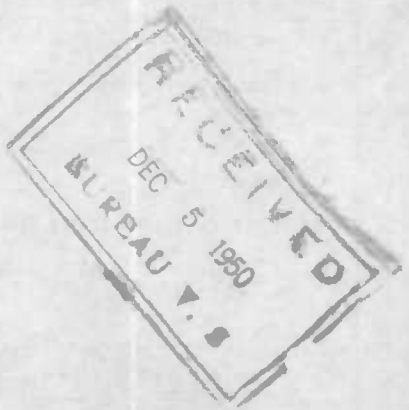
DATE REC'D BY LOCAL REG.: Dec. 1, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George — ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15


RECEIVED
DEC 5 1950
BUREAU V.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

16832

Reg. Dist. No. 4

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH	**2. USUAL RESIDENCE (HOME) OF DECEASED**
COUNTY: ALLEGANY — STATE: MARYLAND	STATE: MARYLAND — COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place): 6 DAYS 32 yrs.	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: CUMBERLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MARYLAND	STREET ADDRESS (If rural, give location): 425 FRANKLIN STREET

3. NAME OF DECEASED (Type or Print)	4. DATE OF DEATH (Month) (Day) (Year)
(First) MABEL (Middle) E. (Last) GREEN	NOV. 28 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
FEMALE	WHITE	MARRIED	OCT. 1, 1889	61 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWORK	Own home	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN CROWE	LILLIAN GREEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Intestinal Obstruction — 48 hrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

420.0 93d

(b) Mesenteric Artery occlusion due to Embolus from ventricular Thrombus — 48 hrs

(c) Myocardial Infarction — 6 days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive and Arteriosclerotic Heart Disease — 2 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
No	No	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
No	No	No	No	

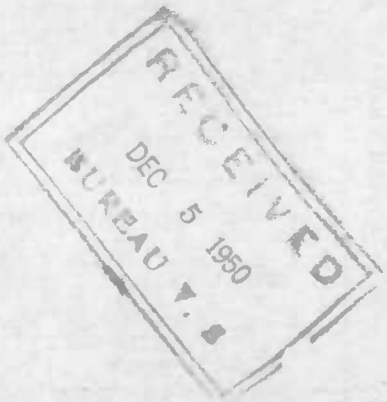
TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
No m.	No	No

22. I hereby certify that I attended the deceased from Fall 47, 1948, to Nov 28, 1950, that I last saw the deceased alive on Nov 27, 1950, and that death occurred at 4:30 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Samuel G. Wiseman	MD	59 Greene St Cumberland	11/30/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 30, 1950	Hillcrest Burial Park	Cumberland Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 30, 1950	Morton R. Kantz, M.D.	John J. Hofer	Cumberland, Md.


RECEIVED
DEC 5 1950
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10833 4

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. It is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland	LENGTH OF STAY (in this place) 24 years
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 600 North Mechanic St	STREET ADDRESS (If rural, give location) 600 North Mechanic St

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Pearl		Guy	Nov 10 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	Colored	Widow	Jan6 1887	63 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House	House Wife	Petersburg, W. Va.	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Beckwith	Hannah Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Mrs. Wm. Stewart, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Adeno carcinoma Cervix Uteri	2 yrs
171X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	
48a (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
About Oct 1948	Biopsy Cervix. Adeno carcinoma	Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from June 14, 1947, to Nov. 10, 1950, that I last saw the deceased alive on Nov. 8, 1950, and that death occurred at 6:15 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M. D.	110 S. Centre St.	Nov. 11, 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov 13 1950	Rose Hill Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 13, 1950	Hunter R. Dantz, M.D.	William H. Kight	Cumberland, Md.

VS. A15

RECEIVED
NOV 14 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10834

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) R. F. D. No 2 Box 200

3. NAME OF DECEASED (Type or Print): (First) Walter (Middle) Eugene (Last) Harden

4. DATE OF DEATH: (Month) 11 (Day) 3 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 4-15-1927

9. AGE last birthday: 23 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Walter A. Harden

14. MOTHER'S MAIDEN NAME: Nellie F. Lunat

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World 2

16. SOCIAL SECURITY NO.: 216-22-5255

17. INFORMANT AND ADDRESS: Mrs Walter E. Harden, Frostburg, Md R.D. No 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
550.1 Immediate cause (a)	Peritonitis	3 days
121 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Acute gangrenous appendicitis	5 days
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 11-2-50

19b. MAJOR FINDINGS OF OPERATION: perforated gangrenous appendix, diffuse purulent peritonitis

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-2, 1950, to 11-3, 1950, that I last saw the deceased alive on 11-3, 1950, and that death occurred at 10 45 a. m., from the causes and on the date stated above.

SIGNATURE: Adolf Wolferman (Degree or title) M.D. ADDRESS: Frostburg, Md DATE SIGNED: 11-3-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 11-5-1950 — NAME OF CEMETERY OR CREMATORY: Frostburg Memorial — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 11-5-50 — REGISTRAR'S SIGNATURE: Mrs. Hallie N. Roe

24. FUNERAL DIRECTOR: Jacob Hafer — ADDRESS: Frostburg, Md.

45412

RECEIVED
NOV 9 1950
BUREAU T. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr. McLane

10835

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 15 American Ave.,

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 15 American Ave.

3. NAME OF DECEASED (Type or Print): (First) AMELIA (Middle) (Last) HAYES

4. DATE OF DEATH: (Month) Nov. (Day) 28, (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
female	white	widowed	1-11-1870	80 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Pittsburgh, Pa.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Sonnenberg	Catherine Raut

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
	none	Lawrence Hayes, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Cardiac Dilatation	Sudden
422.2 **Antecedent cause(s)**	(b) Chr Myocarditis	1 yr.
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Senility	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Nov 16, 1950, to Nov 28, 1950, that I last saw the deceased alive on Nov 16, 1950, and that death occurred at 1:00 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Wm McLane	MD	Frostburg Md	Nov 30 1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11-30-50	Fbg. Memorial Park	Frostburg, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
12-2-50	Mrs. Dawley H Roe	J. R. Durst,	Frostburg, Md.

RECEIVED
DEC 5 1950
BUREAU V. C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10836

Reg. Dist. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) JAMES (Middle) EDWARD (Last) JENKINS

4. DATE OF DEATH: (Month) Nov. (Day) 11, (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 12-4-1867

9. AGE last birthday: 82 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired - Hauling Transfer Self employed

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph T. Jenkins

14. MOTHER'S MAIDEN NAME: Sarah Kalklusher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: John Jenkins, Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Dilatation Heart — Interval Between Onset and Death: 3 or 4 hours

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — 443X 93d

(b) Hypertension Heart Disease — end years

(c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1950, to Nov. 11, 1950, that I last saw the deceased alive on Nov 5, 1950, and that death occurred at 4a m., from the causes and on the date stated above.

SIGNATURE: F. Alan E. Warren (Degree or title): M.D. ADDRESS: Cumberland, Md. DATE SIGNED: Nov 12-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 11-13-1950

NAME OF CEMETERY OR CREMATORY: Methodist Cemetery

LOCATION (City, town, or county) (State): Mt. Savage, Md.

DATE REC'D BY LOCAL REG.: Nov. 12 - 50

REGISTRAR'S SIGNATURE: Vernon McDermitt

24. FUNERAL DIRECTOR: J. R. Durst ADDRESS: Frostburg, Md.

15650

RECEIVED
NOV 15 1950
BUREAU V. S

Within corporate limits

Rees

MARYLAND STATE DEPARTMENT OF HEALTH

16837

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; MARYLAND; LENGTH OF STAY (In this place) 50 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 211 Pennsylvania Ave.

3. NAME OF DECEASED (Type or Print): (First) Joseph; (Middle) Gustel; (Last) Kelley

4. DATE OF DEATH: (Month) Nov; (Day) 18; (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 1/27/73

9. AGE last birthday: 77 yrs.; If under 1 year: Months; Days; If under 24 hrs.: Hours; Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Conductor

10b. KIND OF BUSINESS OR INDUSTRY: B & O. Railroad

11. BIRTHPLACE (State or foreign country): Terra alta W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm I. Kelley

14. MOTHER'S MAIDEN NAME: Hulda Sisler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Joseph Kelley – 211 Penn Ave – City.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial Failure

443 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

93d (b) Hypertensive-C-V. Disease

(c) Senile Sclerosis

Interval Between Onset and Death: (a) 2 hrs; (b) Chronic; (c) Chronic

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 10, 1950, to Nov 18, 1950, that I last saw the deceased alive on Nov 15, 1950, and that death occurred at 7:35 P.M., from the causes and on the date stated above.

SIGNATURE: Wm. Rees, M.D. (Degree or title) ADDRESS 40 Baltimore St Cumberland DATE SIGNED 11/20/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF Nov 20, 1950; NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery; LOCATION (City, town, or county) Cumberland; (State) Md

DATE REC'D BY LOCAL REG. Nov. 20, 1950; REGISTRAR'S SIGNATURE Walter L. Dantz, M.D.

24. FUNERAL DIRECTOR John J. Hafer; ADDRESS Cumberland Md

102 47

Di Rees

Di Rees

RECEIVED
NOV 28 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

10838

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place) 74 yrs
HOSPITAL OR INSTITUTION (If not in either, give STREET ADDRESS) Allegany Co. Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 774 Gephart Drive

3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) Anthony (Last) Kienhofer

4. DATE OF DEATH: (Month) Nov (Day) 27 (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Widowed	June 27 1871	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter	General contractor	Cumberland Md	U S A

13. FATHER'S NAME: Anthony Kienhofer
14. MOTHER'S MAIDEN NAME: Catherine Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No —	217-14-4407	Lewis H. Kienhofer Cumberland Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Myocardial failure	2 wks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Coronary Sclerosis	3 yrs
(c)	Generalized arteriosclerosis	

420.1
940

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Nov. 22, 19 50 to Nov. 27, 19 50, that I last saw the deceased alive on Nov. 25, 19 50, and that death occurred at 7:45 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones M.D.		110 S. Centre St.	Nov. 28, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Nov 28 '50	St. Peter & Paul's Cem	Cumberland	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 28, 1950	Walter K. Lantz, M.D.	Louis Stein Inc	"

34049

RECEIVED
DEC 5 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10839

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland,
STREET ADDRESS (If rural, give location) 418 Fayette St.,

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Benjamin (Last) Kleemann

4. DATE OF DEATH: (Month) Nov. (Day) 23, (Year) 19 50

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 9-2-1895

9. AGE last birthday: 55 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lumber salesman

10b. KIND OF BUSINESS OR INDUSTRY: Radford & Sanders

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY: U. S.

13. FATHER'S NAME: David Kleemann

14. MOTHER'S MAIDEN NAME: Elizabeth Lyell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) W.W. I

16. SOCIAL SECURITY NO.: 579-07-3091

17. INFORMANT AND ADDRESS: Mrs. Ruth S. Kleemann Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval between onset and death: 1 hour

420.1 94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) none

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 23, 1950, to Nov. 23, 1950, that I last saw the deceased alive on Nov. 23, 1950, and that death occurred at 7:30 P m., from the causes and on the date stated above.

SIGNATURE: B. M. Schindler M.D. (Degree or title) ADDRESS 41 Grant St. DATE SIGNED Nov 24/1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 11-27-1950 — NAME OF CEMETERY OR CREMATORY: Baltimore National Cem. — LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REG.: Nov. 24, 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George — ADDRESS: Cumberland, Md.

27809

RECEIVED
NOV 28 1950
BUREAU OF I. &

MARYLAND STATE DEPARTMENT OF HEALTH

10840

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg | LENGTH OF STAY (in this place) 17 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN National
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) William (Middle) C (Last) Landerfeld

4. DATE OF DEATH: (Month) November (Day) 20 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov 9, 1881

9. AGE last birthday: 69 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trackman

10b. KIND OF BUSINESS OR INDUSTRY: Rail Road

11. BIRTHPLACE (State or foreign country): Pottsville, Pa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Landerfeld

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Mrs William Landerfeld

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

001X **Immediate cause** (a) Silicosis a. possible tuberculosis — 10 years

13a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-9, 1950, to 11-20, 1950, that I last saw the deceased alive on 11-20, 1950, and that death occurred at 7 10 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Joseph Doleman M.D. Frostburg, Md. 11-21-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Nov 23, 1950 | NAME OF CEMETERY OR CREMATORY: German Cemetery | LOCATION (City, town, or county) (State): Frostburg, Md

DATE REC'D BY LOCAL REG. 11-22-50 | REGISTRAR'S SIGNATURE: Mrs Nancy N. Roe

24. FUNERAL DIRECTOR: M. Eichhorn — ADDRESS: Lonaconing, Md.

98447

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
NOV 24 1950
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10841

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN National
STREET ADDRESS (If rural give location) R. D. Frostburg

3. NAME OF DECEASED (Type or Print): (First) Agnes (Middle) (Last) Leatherman
4. DATE OF DEATH: (Month) November (Day) 15 (Year) 1950

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: June 10, 1871
9. AGE last birthday: 79 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Durham England
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Steven Emerson
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT: Mrs John Ware daughter

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chr Myocarditis — 6 mo

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Diabetes — 2 yrs

260X
61

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1950, to Nov 13, 1950, that I last saw the deceased alive on Nov 13, 1950, and that death occurred at 6:15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W O M Lane MD — Frostburg Md — Nov 15 1950

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

Burial — Nov 19, 1950 — Frostburg Memorial Park. — Frostburg, Md.

DATE REC'D BY LOCAL REG. 11-17-50 | REGISTRAR'S SIGNATURE Mrs. Daisy N. Roe | 24. FUNERAL DIRECTOR M. Eichhorn | ADDRESS Lonaconing, Md.

VS. A15

RECEIVED
NOV 20 1950
F. A. U.
BUREAU

10842

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Harry (Middle) T. (Last) Lewis
4. DATE OF DEATH (Month) Nov. (Day) 8 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH June 4, 1892
9. AGE last birthday 58 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Helper
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Mt. Savage, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Theodore Lewis
14. MOTHER'S MAIDEN NAME Ida Geary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-07-2722
17. INFORMANT AND ADDRESS Minnie Boyer Lewis, Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Dilatation heart	4 days
592X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypotension Heart Disease	3 years
131 b	(c) Chr. Nephritis	3 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Pneumonitis — 1 year

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1949, 19....., to Nov 8, 1950, that I last saw the deceased alive on Nov 8, 1950, and that death occurred at 11.45 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Adam G. Murray M.D. ADDRESS Cumberland Md DATE SIGNED Nov 10-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov. 12, 1950
NAME OF CEMETERY OR CREMATORY Mt. Savage Methodist
LOCATION (City, town, or county) (State) Mt. Savage, Maryland

DATE REC'D BY LOCAL REG. Nov. 11-50
REGISTRAR'S SIGNATURE Veronica McDermott
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 15 1950
BUREAU T. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10843

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; MARYLAND; LENGTH OF STAY (In this place): 11 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Flintstone; STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James	Fredrick	Logeston	Nov.	29	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs: Hours	Min.
male	white	Married	Feb.4-1917	33 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Service Dept.	Celanese Corp.	Chaneysville Pa.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Logeston	Georgia Etta Bennett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
yes	W.W. 2		(wife) Mrs.Leona Logeston, Flintstone, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Uremia due to	11 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) renal suppression with poisoning	
	(c) (Spirit nitrous ether)	

874.0

178 X

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	home	Flintstone	Allegany	Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☒	HOW DID INJURY OCCUR?
about Nov.14/50 night		History- Drank several bottles of Spt.nitrous ether

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V.Deming M.D.		Cumberland, Md.	Nov.30-1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Dec.2-1950	Hillcrest Burial Park	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Dec. 2, 1950	Walter L. Wantz, M.D.	John J. Hafer, Cumberland, Md.	

XVX 16

RECEIVED
DEC 5 1950
BUREAU V. I.

DR. ELIASON

MARYLAND STATE DEPARTMENT OF HEALTH

16844

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD.
LENGTH OF STAY (in this place) 24
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE PA. COUNTY BEDFORD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BEDFORD
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) LARRY (Middle) E. (Last) LYBARGER

4. DATE OF DEATH: (Month) NOV. (Day) 1 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: NOV. 2, 1949

9. AGE last birthday: 1 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALFRED A. LYBARGER

14. MOTHER'S MAIDEN NAME: MARY WERTZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Alfred Lybarger, Bedford Co Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Retino Blastoma (Right Eye)	6 mos.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Intra Cranial Metastisis	3 mos.
	(c)	

192X
55e

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN): (COUNTY): (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: INJURY OCCURRED While at Work ☐ Not While At work ☐: HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-1-, 1950, to 11-1, 1950, that I last saw the deceased alive on 10-31, 1950, and that death occurred at 6:00 A m., from the causes and on the date stated above.

SIGNATURE: N. W. Eliason (Degree or title) M.D. ADDRESS: 126 N. Mechanic St Cumberland Md DATE SIGNED: 11/2/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Nov. 3 1950 | NAME OF CEMETERY OR CREMATORY: Memorial Park | LOCATION (City, town, or county): Bedford, (State) Pa

DATE REC'D BY LOCAL REG.: Nov 2, 1950 | REGISTRAR'S SIGNATURE: Hunter R Beatty, M.D. | 24. FUNERAL DIRECTOR: Harvey N. Zeigler | ADDRESS: Hyndman, Pa.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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NOV 7 1950
BUREAU V. S.

Registered 10845

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
AGNES	THRESEA	MARSHALL	Nov.	28,	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.
female	white	widowed	11-30-1871	78 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	home	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Peter Feldman	Mary Farley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
	none	Lillian Feldman, Eckhart, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocarditis - Arteriosclerotic	at least 3 yrs.
Antecedent cause(s)		
442 X 131 a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic Cardiovascular renal disease	15 to 20 yrs.
	(c) Hypertension	.. .. ..

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
NONE	✓	Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
NONE	NONE	✓		

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
NONE m.		

22. I hereby certify that I attended the deceased from SEPT. 23, 1948, to NOV. 28, 1950, that I last saw the deceased alive on Nov. 28, 1950, and that death occurred at 1:00 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Martin M Rothstein	M.D.	48 BROADWAY FROSTBURG	11/29/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	12-1-1950	St. Michaels Cemetery	Frostburg, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11-30-50	Mrs. Nancy V. Roe	J. R. Durst, Frostburg, Md.	

RECEIVED
DEC 4 1950

Dr. D. T. Rees
Call Scarpelli

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10846

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: West Virginia — COUNTY: Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 33 Yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Wiley Ford W.Va.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Catherine McAbee			4. DATE OF DEATH (Month) (Day) (Year): Nov. 2 1950		
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: 11-6-1873	9. AGE last birthday: 77 yrs.	If under 1 year: Months. Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country): Gettsburg, Pa. Pa.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: John Miltenberger			14. MOTHER'S MAIDEN NAME: Dorthey Laffleman		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)		16. SOCIAL SECURITY NO.: None	17. INFORMANT: Son John McAbee		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial failure	14 days
443X Antecedent cause(s)	(b) Hypertensive C-V Disease	[illegible]
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) [illegible]	[illegible]

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Gangrene Right Foot — 6 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 2, 1950, to Nov 2, 1950, that I last saw the deceased alive on Nov 1, 1950, and that death occurred at 5 a m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jesse T Rees	MD	40 Decatur Cumberland	11/5/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 11/4/50	NAME OF CEMETERY OR CREMATORY: St. Peter and Paul Cem.	LOCATION (City, town, or county) (State): Cumberland, Md.
DATE REC'D BY LOCAL REG.: Nov 3, 1950	REGISTRAR'S SIGNATURE: Winter R Crantz, MD	24. FUNERAL DIRECTOR: James F. Scarpelli	ADDRESS: Cumberland, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr Reed.

RECEIVED
NOV 7 1950
BUREAU V. S

Within corporate limits Dr. Murray

10847

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 8 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 424 N. Mechanic St.

3. NAME OF DECEASED (Type or Print) (First) Louis (Middle) Henry (Last) McKenzie

4. DATE OF DEATH (Month) Nov (Day) 5 (Year) 1950

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH May 5, 1885

9. AGE last birthday 65 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Washer in laboratory

10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp. of Amer.

11. BIRTHPLACE (State or foreign country) Somerset Co. Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Francis McKenzie

14. MOTHER'S MAIDEN NAME Leah Warner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-03-1106

17. INFORMANT AND ADDRESS Leola Burkett, Corrigansville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
523.0 Immediate cause	(a) Acute Dilatation Heart	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Silicosis advanced	10 years
114a	(c) Asthma of Heart failure	2 months

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 10, 1950, to Nov 5, 1950, that I last saw the deceased alive on Nov 5, 1950, and that death occurred at 1:45 P.m., from the causes and on the date stated above.

SIGNATURE F. Alan G. Murray (Degree or title) Md ADDRESS Cumberland DATE SIGNED Md Nov 7

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF Nov. 8, 1950 NAME OF CEMETERY OR CREMATORY Greenville Cemetery LOCATION (City, town, or county) Somerset Co. (State) Pa.

DATE REC'D BY LOCAL REG. Nov. 8, 1950 REGISTRAR'S SIGNATURE Peter R. Krantz M.D. 24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Md. ADDRESS

49616

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

D. Murray

RECEIVED
NOV 14 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) JOSEPH (Middle) (Last) MEARS

4. DATE OF DEATH: (Month) Nov. (Day) 5, (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 4-5-1868

9. AGE last birthday: 82 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired miner

10b. KIND OF BUSINESS OR INDUSTRY: coal mines

11. BIRTHPLACE (State or foreign country): Wales

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Mears

14. MOTHER'S MAIDEN NAME: Caudill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: 160-18-2019A

17. INFORMANT AND ADDRESS: Wm. Mears, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151x **Immediate cause** (a) Carcinoma of stomach. — Interval Between Onset and Death: one year

46 b **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Hypertensive C-V disease. —
(c) Secondary anemia. —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility —

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-1, 1950, to 11-5, 1950, that I last saw the deceased alive on 11-5, 1950, and that death occurred at 2 a. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): H. C. Diehl, M.D. ADDRESS: Frostburg, Md. DATE SIGNED: 11/6/50.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 11-8-1950
NAME OF CEMETERY OR CREMATORY: Fbg. Memorial Park
LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 11-6-50
REGISTRAR'S SIGNATURE: Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR: J. R. Durst, ADDRESS: Frostburg, Md.

154 02

RECEIVED
NOV 9 1950
BUREAU V. S

Within corporate limits

Dr. Simond

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10849

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 87 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9 Decatur St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 9 Decatur St.

3. NAME OF DECEASED (Type or Print): (First) Margaret (Middle) Socla (Last) Miller

4. DATE OF DEATH (Month) (Day) (Year): Nov 27 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Sept 14, 1857

9. AGE last birthday: 93 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Pleasant Union Pa

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: John Miller

14. MOTHER'S MAIDEN NAME: Martha Keilman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS: Ida Miller, 9 Decatur St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion — Interval Between Onset and Death: 2 weeks

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — (b) Myocardial degeneration

94a (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

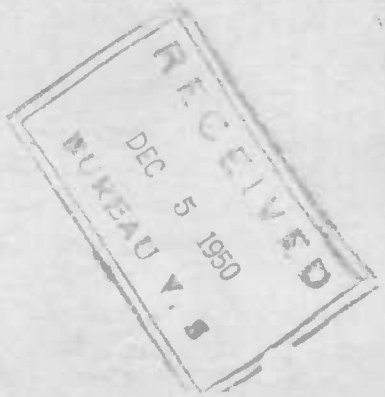
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1949, to Nov 27, 1950, that I last saw the deceased alive on Nov 27, 1950, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) George M Brown M.D. — ADDRESS Cumberland Md — DATE SIGNED 11/28/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF Nov. 29, 1950 — NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum — LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Nov. 29, 1950 — REGISTRAR'S SIGNATURE Walter K. Hantz, M.D. — 24. FUNERAL DIRECTOR John J. Hafer, Cumberland, Md. — ADDRESS


RECEIVED
DEC 5 1950
MUKEAU V.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10850

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland. LENGTH OF STAY (in this place) 40 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 609 Elm St.

3. NAME OF DECEASED (Type or Print) (First) Nettie (Middle) Hetterly (Last) Miller
4. DATE OF DEATH (Month) Nov (Day) 13 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH April 19 1879
9. AGE last birthday 71 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Thurmont Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Wm H Hetterly
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Mrs John R. Dorn, Cumbd Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) coronary occlusion	29 hrs.
420.1 94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arterial hypertension	years
	(c) coronary heart disease	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/29, 1946, to Nov. 13, 1950, that I last saw the deceased alive on Nov. 13, 1950, and that death occurred at 9 45 A m., from the causes and on the date stated above.

SIGNATURE Elizabeth Brings (Degree or title) M.D. ADDRESS 55 Green St. DATE SIGNED 11/15/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov 16 1950
NAME OF CEMETERY OR CREMATORY Hillcrest Cem
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Nov. 16, 1950
REGISTRAR'S SIGNATURE Dieter R. Frantz, M.D.
24. FUNERAL DIRECTOR Louis Stein, Inc. ADDRESS Cumberland Md

RECEIVED
NOV 21 1950

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

16851

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) MARYLAND 50 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 179 Frederick St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 179 Frederick St.

3. NAME OF DECEASED (Type or Print): (First) Emma (Middle) M. (Last) Montgomery

4. DATE OF DEATH: (Month) (Day) (Year) Nov. 15, 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: May 30 1877

9. AGE last birthday: 73 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Quincy, Illinois

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Andrew [illegible]

14. MOTHER'S MAIDEN NAME: Virginia Tweed

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs Robert F Nicholls, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	8 days
331X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 83a	(b) Arterial hypertension	1 year
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 14, 1950, to Nov 15, 1950, that I last saw the deceased alive on Nov 14, 1950, and that death occurred at 11 15 A m., from the causes and on the date stated above.

SIGNATURE: R. F. Trewaskes Jr (Degree or title) ADDRESS: Cumberland, Md DATE SIGNED: Nov. 16 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Nov 17 50 | NAME OF CEMETERY OR CREMATORY: Rose Hill Cem | LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: Nov. 16 1950 | REGISTRAR'S SIGNATURE: Peter K. Krantz M.D. | 24. FUNERAL DIRECTOR: Louis Stein Inc | ADDRESS: Cumberland Md.

RECEIVED
NOV 21 1950
U.S. AIR FORCE

DR. WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10852

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: PENNSYLVANIA COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: NEW PARIS Pa.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) BABY (Middle) BOY (Last) MOORE			4. DATE OF DEATH (Month) NOVEMBER (Day) 3. (Year) 1950		
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE	8. DATE OF BIRTH: 11/3/50	9. AGE last birthday: yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours 0 / Min. 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: ROSS S. MOORE		14. MOTHER'S MAIDEN NAME: ANNA LEE HOLLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Edema.

760.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Poly Hydramnios (maternal)

161c (c) Diabetes Mell Maternal Sense

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3 Nov, 1950 to 3 Nov, 1950, that I last saw the deceased alive on 3 Nov, 1950, and that death occurred at 11:05 P.m., from the causes and on the date stated above.

SIGNATURE: Fuller B. Whitworth (Degree or title) MD — ADDRESS: Cumberland Md — DATE SIGNED: 4 Nov 50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: Nov 5, 1950	NAME OF CEMETERY OR CREMATORY: Schellsburg Cem.	LOCATION (City, town, or county): Schellsburg (State) Pa.
DATE REC'D BY LOCAL REG.: Nov. 4, 1950	REGISTRAR'S SIGNATURE: Winter R. Trantz, MD	24. FUNERAL DIRECTOR: J. Ralph Mickle	ADDRESS: Schellsburg Pa.

20X030252406

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 17 1950
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

16853

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural) Cumberland
LENGTH OF STAY (in this place) about 50yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS about 1/4 mile east of Shipway Inn. Route 40

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
STREET ADDRESS (If rural give location) R.F.Droute #40

3. NAME OF DECEASED (Type or Print) (First) Cora (Middle) Belle (Last) Morgan

4. DATE OF DEATH (Month) Nov. (Day) 1 (Year) 1950

5. SEX female

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow

8. DATE OF BIRTH March-1879

9. AGE last birthday 71 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Green Ridge Mt.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Gordon

14. MOTHER'S MAIDEN NAME Harriett Middleton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. ----

17. INFORMANT Lulu Clingerman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
443X	Immediate cause	(a) Chronic myocarditis	5 yrs
93d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis with hypertention.	?
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Nov. 1-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 11/3/50

NAME OF CEMETERY OR CREMATORY Green Ridge Cemetery

LOCATION (City, town, or county) (State) Allegany Co. Md

DATE REC'D BY LOCAL REG. 11-2-50

REGISTRAR'S SIGNATURE Lester R. Krantz M.D.

24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
NOV 7 1950
BUREAU V. S.

Within corporate limits

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10854

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 29 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Cumberland, Rural
STREET ADDRESS (If rural, give location) Valley Road, R.F.D. #3

3. NAME OF DECEASED (Type or Print) (First) ALONZA (Middle) (Last) MORT

4. DATE OF DEATH (Month) (Day) (Year) Nov. 27, 1950 19

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH May 30, 1893

9. AGE last birthday 57 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY Rayon (Celanese Corp.)

11. BIRTHPLACE (State or foreign country) Hancock, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Mort

14. MOTHER'S MAIDEN NAME McCusker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW 1

16. SOCIAL SECURITY NO. 214-07-1954

17. INFORMANT AND ADDRESS Mrs. Frances Dicken, Frederick, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
401.0	Immediate cause	(a) Myocardial failure, acute (+ chronic)	1 hr (7 wk)
92 d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Pericarditis, acute and chronic	20 yrs
		(c) Rheumatic Heart Disease, active + inactive	30 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Aortic valvulitis, chronic — 30 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1947, to Nov 27, 1950, that I last saw the deceased alive on Nov 24, 1950, and that death occurred at 8:15 p.m., from the causes and on the date stated above.

SIGNATURE Saville G Weisman MD (Degree or title) ADDRESS 59 Greene St Cumberland, Md DATE SIGNED 11/29/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Nov. 30, 1950

NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery

LOCATION (City, town, or county) (State) RFD Hancock, Md.

DATE REC'D BY LOCAL REG. Nov. 29, 1950

REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR William H. Kight, Cumberland, Md. ADDRESS

42016

DR. WEISMAN

RECEIVED
DEC 5 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

DR. JACOBSON

2411 N. Charles Street, Baltimore

16855

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 13 HRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPIYAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY ALLEG
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN OLDTOWN MD
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) PETER (Middle) H.enry (Last) MOUSE

4. DATE OF DEATH (Month) NOV (Day) .12. (Year) 50 19

5. SEX MALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED

8. DATE OF BIRTH DEC 28, 1864

9. AGE last birthday 85 yrs.

If under 1 year: Months / Days

If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY Owner Farming

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? ALLEG

13. FATHER'S NAME PERERM MOUSE

14. MOTHER'S MAIDEN NAME MOORE. MARY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS Mrs Herman Twigg Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Coronary Insuffiency	1 day.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension & Coronary Artery Disease	2
	(c)	c

420.1 9th

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. –

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION –

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1.0, 19 45, to Nov. 12, 19 50, that I last saw the deceased alive on Nov 12, 19 50, and that death occurred at 2 20 p.m., from the causes and on the date stated above.

SIGNATURE Samuel Jacobson (Degree or title) M.D. ADDRESS 50 Pershing St. DATE SIGNED 11/13/50

23. BURIAL, CREMATION / REMOVAL (Specify) Burial | DATE THEREOF Nov 15 50 | NAME OF CEMETERY OR CREMATORY St Peters Cemetery | LOCATION (City, town, or county) Hancock (State) Md

DATE REC'D BY LOCAL REG. Nov. 16 1950 | REGISTRAR'S SIGNATURE Gustav R. Krantz, M.D. | 24. FUNERAL DIRECTOR William Wright ADDRESS Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 21 1950
U. S. PATENT

10856

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Cumberland
LENGTH OF STAY (In this place) 1 yr. 6 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural) Cumberland
STREET ADDRESS (If rural, give location) R.F.D #4 Box 107 Mexico Farms

3. NAME OF DECEASED (Type or Print) (First) Larry (Middle) Lester (Last) Myers
4. DATE OF DEATH (Month) Nov. (Day) 4 (Year) 1950
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH July 7-1949
9. AGE last birthday 1 yrs. If under 1 year Months 3 Days If under 24 hrs Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----
10b. KIND OF BUSINESS OR INDUSTRY ------
11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Otha Walson Myers
14. MOTHER'S MAIDEN NAME Leona Jeanette Hare
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY No. ------
17. INFORMANT AND ADDRESS Mother) R.F.D #4 Mexico Farms

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute cardiac failure due to a	at once
754.4 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) congenital heart lesion. (blue baby)	about 14 months
157 e	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Nov.4-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov. 7 1950
NAME OF CEMETERY OR CREMATORY Zion Mem Park
LOCATION (City, town, or county) Cumberland (State) Md
DATE REC'D BY LOCAL REG. Nov. 6 1950
REGISTRAR'S SIGNATURE Hunter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer, Cumberland Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
NOV 7 1950
U.S. DEPARTMENT OF

Dr. A. F. Jones

Within corporate limits

10857

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 46yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 437 Grand Avenue

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Minerva	L.	Northcraft	Nov.	12	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widowed	10-8-1867	83 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Pennsylvania	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Solomon Smith	Hannah Northcraft

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no	None	Memorial Hospital. Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinoma Liver	6 mo
155X 46f Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) (Primary)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Mar., 1947, to Nov. 12, 1950, that I last saw the deceased alive on Nov. 11, 1950, and that death occurred at 3:15 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Arthur F. Jones	M.D.	110 S. Centre St.	Nov. 13/1950

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	II/15/50	Fairview Cemetery	Greenridge, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Nov. 14, 1950	Pinter R. Krantz, M.D.	James F. Scarpelli Cumberland, Md.

RECEIVED
NOV 21 1950
BUREAU V. S

Evidence for change in #8 shown on:

FILM No. G 1 ,0 JAN 25 1951

10858

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Illinois COUNTY Morgan
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jacksonville
STREET ADDRESS (If rural, give location) Route 3

3. NAME OF DECEASED (Type or Print) (First) MARY (Middle) C (Last) ORRIS
4. DATE OF DEATH (Month) Nov (Day) 11 (Year) 1950
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 3-13-1918
9. AGE last birthday 31 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Jacksonville, Ill
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Wm. H. Sorrill
14. MOTHER'S MAIDEN NAME Bertha Waterfield
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Maurice Orris

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Shock	?
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Comp. Fracture Rt. Ulna at olecranon	6 hours
	(c) Fractured Rt. 3,4,5 Ribs with lung Puncture + Emphysema	"

825.5
170c

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road on East side of Little Savage, (CITY OR TOWN) Frostburg (COUNTY) Garr. Co. (STATE) Md.
TIME OF INJURY (Month) Nov (Day) 10 (Year) 50 (Hour) 7:35 P.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Auto accident

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Thomas F Lusby M.D. (Degree or title) Acting Med. Exam. ADDRESS Oakland, Md DATE SIGNED 11 Nov 50

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE THEREOF 11-12-1950
NAME OF CEMETERY OR CREMATORY Jacksonville, Ill.
LOCATION (City, town, or county) Jacksonville, Ill. (State)
DATE REC'D BY LOCAL REG. 11-12-50
REGISTRAR'S SIGNATURE Mrs. Nancy H Roe
24. FUNERAL DIRECTOR Jacob Hafer, ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
NOV 16 1950
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) DONALDSON (Last) PORTER

4. DATE OF DEATH: (Month) Nov. (Day) 3 (Year) 19 50

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single

8. DATE OF BIRTH: 9-22-1866

9. AGE last birthday: 84 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: self-employed

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Porter

14. MOTHER'S MAIDEN NAME: Mary Caruthers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: Mary Lemmert, Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Chronic Myocarditis	3 years -
592X **Antecedent cause(s)**	Mitral Stenosis	3 years -
1312 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Nephritis -	?
	(c) Extreme anaemia -	6 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from 10/20, 19 50, to 11/3, 19 50, that I last saw the deceased alive on 11/3, 19 50, and that death occurred at 9:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): William E. Moseley M.D. — ADDRESS: Mt George, Md. — DATE SIGNED: November 4. 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Nov. 6 -50 — NAME OF CEMETERY OR CREMATORY: St. George's Cemetery — LOCATION (City, town, or county) (State): Mt. Savage, Md.

DATE REC'D BY LOCAL REG.: 11-6-50 — REGISTRAR'S SIGNATURE: Vernon McDermott

24. FUNERAL DIRECTOR — ADDRESS: J. R. Durst, Frostburg, Md.

30419

RECEIVED
NOV 8 1950
BUREAU Y. R.

DR. TOLSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10860

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND,
LENGTH OF STAY (in this place) 32 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD
STREET ADDRESS (If rural, give location) 404 PULASKI ST.,

3. NAME OF DECEASED (Type or Print) (First) LUCY (Middle) E. (Last) REITH
4. DATE OF DEATH (Month) NOV. 1 (Day) (Year) 1950
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH OCT. 14 1874
9. AGE last birthday 76 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) PA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME MILLER, CHRISTIAN
14. MOTHER'S MAIDEN NAME MARY ANN SMITH
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Margaret Reith, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic nephritis with Uremia

592X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

131a (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis, myocardial degeneration

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-17-, 1950, to 11-1-, 1950, that I last saw the deceased alive on 10-31-, 1950, and that death occurred at 2:05 A.m., from the causes and on the date stated above.

SIGNATURE Howard L. Tolson, M.D. (Degree or title) ADDRESS Cumberland, Md. DATE SIGNED 11-1-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov. 3, 1950
NAME OF CEMETERY OR CREMATORY Hill Crest Burial Park
LOCATION (City, town, or county) Cumberland, Md. (State)
DATE REC'D BY LOCAL REG. Nov 3, 1950
REGISTRAR'S SIGNATURE Winter R. Crantz, M.D.
24. FUNERAL DIRECTOR William H. Kight, Cumberland, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 17 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

10861

Reg. Dist. No. 6

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural near McCoole
MARYLAND — LENGTH OF STAY (In this place): about 10 min
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Route 220 East side of Burkes Hill

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: W.Va. COUNTY: Hampshire
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Keyser
STREET ADDRESS (If rural give location): R.F.D. #1 Knobley Mt. Road

3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) Brooke (Last) Rexrode

4. DATE OF DEATH: (Month) Nov. (Day) 17 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: June 12-1902

9. AGE last birthday: 48 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal trucker

10b. KIND OF BUSINESS OR INDUSTRY: Hawling coal

11. BIRTHPLACE (State or foreign country): Lahmansville W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Aldine Rexrode

14. MOTHER'S MAIDEN NAME: Amy Ours

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 234-42-9486

17. INFORMANT: Kenneth Rexrode (son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH: about 10 min.

Immediate cause (a) Burned to death

824.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Trapped in cab of burning overturned coal

1700 (c) truck.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Right rear wheel of dual truck came off.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): highway Route 220 (CITY OR TOWN): near Mc.Coole (COUNTY): Allegany (STATE): Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute): Nov. 17/50 8:48 A. m.
INJURY OCCURRED While at work ☒ Not while at work ☐
HOW DID INJURY OCCUR? Right rear dual wheel came off of coal truck, turned over.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V. Deming M.D. H. V. Deming M.D. ADDRESS: Cumberland, Md. DATE SIGNED: Nov. 17-1950

23. BURIAL, CREMATION, REMOVAL (Specify): burial
DATE THEREOF: 11-19-1950
NAME OF CEMETERY OR CREMATORY: Thrush Cemetery
LOCATION (City, town, or county) (State): Antioch, W. Va.

DATE REC'D BY LOCAL REG.: Nov. 19/50
REGISTRAR'S SIGNATURE: [illegible] M.D.
24. FUNERAL DIRECTOR: Rogers Funeral Home
ADDRESS: Keyser W.Va.

42002

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
NOV 21 1950

Within corporate limits

10862

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 126 Bedford Street

3. NAME OF DECEASED (Type or Print) (First) Harry (Middle) Gilbert (Last) Rice
4. DATE OF DEATH (Month) Nov (Day) 5 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH April 6, 1876
9. AGE last birthday 74 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor
10b. KIND OF BUSINESS OR INDUSTRY Municipal Gov't
11. BIRTHPLACE (State or foreign country) Twiggtown, Maryland
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Columbus Rice
14. MOTHER'S MAIDEN NAME Emma Hamilton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Miss Mary Ruth Rice, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) apoplectic stroke	2 weeks
331X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) generalized arteriosclerosis	2 years
83a	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-4, 1948, to 12-5, 1950, that I last saw the deceased alive on 12-5, 1950, and that death occurred at 11 A m., from the causes and on the date stated above.

SIGNATURE L. Winters (Degree or title) MD ADDRESS 57 Greene St. DATE SIGNED 12-6-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov 8 1950
NAME OF CEMETERY OR CREMATORY Pleasant Grove
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Dec. 7, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR ADDRESS William H. Kight, Cumberland, Md.

74098

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
DEC 12 1950
BUREAU V. S

Evidence for addition in 18 shown on:

FILM No. G 12 DEC 1 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10863

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Zihlman
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Zihlman
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Idella (Middle) (Last) Rizer
4. DATE OF DEATH (Month) 11 (Day) 17 (Year) 1950
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Oct. 8 - 1908
9. AGE last birthday 42 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Alfred Rizer
14. MOTHER'S MAIDEN NAME Lucy Pope
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Mrs Clifford Green, Lonaconing, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

174X Immediate cause (a) Carcinomatosis - Uterus - original site (11-30-50 - ams) — INTERVAL BETWEEN ONSET AND DEATH ??

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

48b (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Malnutrition — ✓!

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) NONE
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 17, 1950, to Nov. 17, 1950, that I last saw the deceased alive on Nov. 17, 1950, and that death occurred at 8:00 P.m., from the causes and on the date stated above.

SIGNATURE Martinita Rothstein (Degree or title) M.D. ADDRESS 48 Broadway - Frostburg DATE SIGNED 11/18/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 11-20-1950
NAME OF CEMETERY OR CREMATORY Frostburg Memorial
LOCATION (City, town, or county) Frostburg (State) Md.
DATE REC'D BY LOCAL REG. 11-20-50
REGISTRAR'S SIGNATURE Mrs. Nancy H. Rice
24. FUNERAL DIRECTOR Jacob Hafer, Frostburg, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 24 1950
BUREAU OF

10864

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 216 Saratoga St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 223 N. Lee St.

3. NAME OF DECEASED (Type or Print) (First) Barbara (Middle) Elizabeth (Last) Rohman
4. DATE OF DEATH (Month) Nov. (Day) 4, (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH July 1, 1876
9. AGE last birthday 74 yrs. If under 1 year Months — Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Lonaconing Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Francis S. Meyers
14. MOTHER'S MAIDEN NAME Mary C Britten

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. -
17. INFORMANT AND ADDRESS Francis C Rohman.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerosis, generalized — INTERVAL BETWEEN ONSET AND DEATH Two years

450.0

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

97

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ——, 1938, to 11-4, 1950, that I last saw the deceased alive on 11-3, 1950, and that death occurred at 1.50 A.m., from the causes and on the date stated above.

SIGNATURE James T. Johnson Jr. (Degree or title) M.D. ADDRESS Cumberland Md DATE SIGNED 11-6-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov 7, 50
NAME OF CEMETERY OR CREMATORY Sts Peter & Paul's Cem
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Nov. 6 1950
REGISTRAR'S SIGNATURE Hunter R Frantz M.D.
24. FUNERAL DIRECTOR Louis Stein, Inc. ADDRESS Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
NOV 7 1950
BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

10865

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 9 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Pennsylvania — County Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bedford Valley
STREET ADDRESS (If rural, give location) Bedford R.D.3

3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) Reese (Last) Rose

4. DATE OF DEATH (Month) (Day) (Year): 11.25.50 19

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 8.6.1881

9. AGE last birthday: 69 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer Retired

10b. KIND OF BUSINESS OR INDUSTRY: Own farm

11. BIRTHPLACE (State or foreign country): Bedford County, Penna

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emanuel Rose

14. MOTHER'S MAIDEN NAME: Laura Wertz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Elsie Rose, Bedford Valley, Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: 9 days

4201
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
944
(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-15, 1950 to 11-25, 1950 that I last saw the deceased alive on 11-24, 1950 and that death occurred at 7:15 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) James J. Jobes M.D. — ADDRESS Cumberland Md — DATE SIGNED 11-27-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 11.28.50 — NAME OF CEMETERY OR CREMATORY: Bethel Cemetery — LOCATION (City, town, or county) (State): Bedford, Pa. R.D.3

DATE REC'D BY LOCAL REG.: Nov. 27, 1950 — REGISTRAR'S SIGNATURE: Walter K. Frantz M.D.

24. FUNERAL DIRECTOR: Harvey H. Zeigler, Hyndman, ADDRESS Pa.

0006

RECEIVED
DEC 5 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 10866 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS in auto, in route to the Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural give location) Detmold, St.

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Jane (Last) Salisburg
4. DATE OF DEATH (Month) Nov. (Day) 7 (Year) 1950
5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married
8. DATE OF BIRTH March 27-1888
9. AGE last birthday 62 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY ---
11. BIRTHPLACE (State or foreign country) Lonaconing, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Dorah Dawson
14. MOTHER'S MAIDEN NAME Ida Foutz
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ---
17. INFORMANT Lindley Green

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Pulmonary hemorrhage due to punctured lung from fractured ribs, also fractured cervical vertebrae. Also had a compound comminuted froacture right lower leg & fractured left ankle. Hit by an automobile.	about 15 minutes
812.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 170c	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) route #36 Highway
(CITY OR TOWN) National near Frostburg (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) Nov. (Day) 7/50 (Year) 6:30 P. m. (Hour)
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Crossed road in back of parked car & hit by a passing car.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE H.V.Deming M.D. (Degree or title) H. V. Deming M.D. ADDRESS Cumberland, Md. DATE SIGNED Nov.7-1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov 11, 1950
NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery
LOCATION (City, town, or county) Lonaconing, (State) Md.

DATE REC'D BY LOCAL REG. 11-10-50
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR M. Eichhorn ADDRESS Lonaconing, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
NOV 11 1950
BUREAU V. S

Within corporate limits DR. SCHINDLER

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10867

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: ALLEGANY MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: WEST VIRGINIA COUNTY: MINERAL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place): 5 HOURS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: RIDGELEY
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL	STREET ADDRESS (If rural, give location): CARPENTERS ADDITION ✓

3. NAME OF DECEASED (Type or Print)	(First) WILLIAM	(Middle) HENRY	(Last) SELF	4. DATE OF DEATH	(Month) NOV.	(Day) 22	(Year) 1950
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE	8. DATE OF BIRTH: AUG. 9, 1941	9. AGE last birthday: 9 yrs.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student	10b. KIND OF BUSINESS OR INDUSTRY: School	11. BIRTHPLACE (State or foreign country): WEST VIRGINIA Romney	12. CITIZEN OF WHAT COUNTRY? USA.				
13. FATHER'S NAME: VAN SELF	14. MOTHER'S MAIDEN NAME: EDNA NICKELSON						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Meningitis (Epidemic)	1 day
057.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) none	
6	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 22, 1950, to Nov. 22, 1950, that I last saw the deceased alive on Nov. 22, 1950, and that death occurred at 6:37 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
B. M. Schindler	MD	41 Greenwood, Cumberland Md	Nov. 24 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY ~~OR CREMATORY~~	LOCATION (City, town, or county)	(State)
Burial	24 NOV '50	Moyer Cemetery	Romney	W. Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 24, 1950	Winter R. Frantz, MD	A. C. Ruckman	Romney W. Va.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

RECEIVED
NOV 28 1950
BUREAU V. S.

Within corporate limits

DR. ENFIELD

10868

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 8 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA COUNTY HAMPSHIRE
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ROMNEY
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) ELTA (Middle) S. (Last) SHANHOLTZER

4. DATE OF DEATH (Month) NOVEMBER (Day) 19, (Year) 1950

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH NOV. 24, 1875
9. AGE last birthday 74 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY House
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME SAMUEL LOY
14. MOTHER'S MAIDEN NAME ELIZABETH YOST

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL -CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Edema Cardiac Failure.

903.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Fractured femur

186a (c)

INTERVAL BETWEEN ONSET AND DEATH: 5 hours

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) accident
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home (CITY OR TOWN) Romney (COUNTY) Wva (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) Nov 10 m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? Fall in kitchen.

22. I hereby certify that I attended the deceased from Nov 10, 1950, to Nov 19, 1950, that I last saw the deceased alive on Nov 18, 1950, and that death occurred at 3:15 Am., from the causes and on the date stated above.

SIGNATURE S. C. Enfield (Degree or title) ADDRESS DATE SIGNED 11/19/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov 21/50
NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery
LOCATION (City, town, or county) Romney WVa (State)

DATE REC'D BY LOCAL REG. Nov. 19, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR Merge Combs ADDRESS Romney WVa

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

RECEIVED
NOV 28 1950
BUREAU 7.3

Within corporate limits DR. ELIASON

MARYLAND STATE DEPARTMENT OF HEALTH

10869

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND, MD. — LENGTH OF STAY (in this place) 2½ HRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 36 RACE STREET

3. NAME OF DECEASED (Type or Print): (First) BERNARD (Middle) F. (Last) SMITH
4. DATE OF DEATH: (Month) NOV. (Day) 22 (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE	MARRIED	NOV. 4, 1886	64 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Section Stockman
10b. KIND OF BUSINESS OR INDUSTRY: Store Dept Railroad
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: EDWARD B. SMITH
14. MOTHER'S MAIDEN NAME: ANNA HANLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 705-05-44II
17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Pernicious Anemia	15 yrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypo Thyroidism	15 yrs
422.2 630 (c) Clinic Myocarditis.	15 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Elephantiasis.	15 yr.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-15, 1950, to 11-22, 1950, that I last saw the deceased alive on 11-22, 1950, and that death occurred at 9:25 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
H W Eliason M.D. 126 Howard St Cumberland Md

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11/25/50	Rose Hill Cem	Cumberland, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Nov 24, 1950	Walter R. Dantz, M.D.	James F. Scarpelli Cumberland, Md

496 47

RECEIVED
NOV 28 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

16870

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 246 Columbia St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 246 Columbia St.

3. NAME OF DECEASED (Type or Print): (First) Bessie (Middle) Rebecca (Last) Smith

4. DATE OF DEATH: (Month) Nov. (Day) 1, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 11-30-1891

9. AGE last birthday: 59 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Diva Dove

11. BIRTHPLACE (State or foreign country): Allegany Grove, Md.

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: John Finley

14. MOTHER'S MAIDEN NAME: Harriet Ann Starkey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Edward D. Smith Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) coronary heart disease — Interval Between Onset and Death: 4 yrs.

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arterial hypertension

94a (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1, 1946 to Nov. 1, 1950, that I last saw the deceased alive on Nov. 1, 1950, and that death occurred at 12 15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Elizabeth Briggs M.D. 55 Greene St. 11/2/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 11-3-1950 | NAME OF CEMETERY OR CREMATORY: Porter Cem. | LOCATION (City, town, or county) (State): Eckhart, Md.

DATE REC'D BY LOCAL REG.: Nov. 3, 1950 | REGISTRAR'S SIGNATURE: Walter L. Krantz, M.D.

24. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.

VS. A15

RECEIVED
NOV 7 1950
BUREAU V. S

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10871

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural Cumberland
LENGTH OF STAY (in this place): 9 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: R.F.D.#2 Williams road

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: (rural) Cumberland
STREET ADDRESS (If rural, give location): R.F.D.#2 Williams Road

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Lorring	Carl	Smith	Nov.	29	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	divorced	Dec.27-1893	56 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer & Chauffeur	Driving cars	Gilpen Town Md.	U.S.A.

13. FATHER'S NAME: John H.Smith

14. MOTHER'S MAIDEN NAME: Florence De Haven

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes W.W.I

16. SOCIAL SECURITY NO.: 215-12-2064

17. INFORMANT AND ADDRESS: sister) Edna Browning, La Vale, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	?
	(c)	

420.1
940a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ✱, Inquiry ✱ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ✱ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

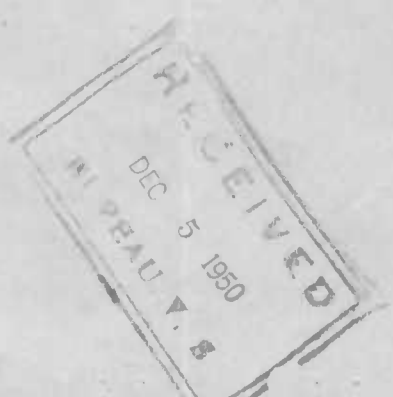
SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H. V. Deming M.D.		Cumberland, Md.	Nov.30-1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Dec.3,1950	Fairview Cem.	Balto. Pike near Flintstone, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Dec. 1, 1950	Walter R. Tantz, M.D.	Charles L. George	Cumberland, Md.

VS. A15A

42099


RECEIVED
DEC 5 1950
BUREAU V. S.

Within corporate limits

Dr Weisman

10872

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 45 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 202 Maryland Ave

3. NAME OF DECEASED (Type or Print) (First): Aloysious (Middle): Wendell (Last): Straub
4. DATE OF DEATH (Month): Nov. (Day): 25 (Year): 1950

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: May 8 1874
9. AGE last birthday: 76 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secy & Treas.
10b. KIND OF BUSINESS OR INDUSTRY: Coal Co.
11. BIRTHPLACE (State or foreign country): Bedford Co Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Casper A Straub
14. MOTHER'S MAIDEN NAME: Catherine Gondon.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-05-5970
17. INFORMANT AND ADDRESS: Mrs Margaret R. Straub, Cumbd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a)	Bronchopneumonia	7 days
331X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Cerebral hemorrhage ("stroke")	8 days
83a	(c)	Hypertension	10 years? uncertain

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis — 10 years? uncertain

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): no
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): no — (CITY OR TOWN): no — (COUNTY) — (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour): no m.
INJURY OCCURRED While at Work ☐ Not While At work ☐: no
HOW DID INJURY OCCUR? no

22. I hereby certify that I attended the deceased from Nov 17, 1950, to Nov 25, 1950, that I last saw the deceased alive on Nov 24, 1950, and that death occurred at 6 05 A m., from the causes and on the date stated above.

SIGNATURE: Saville G Weisman MD (Degree or title) — ADDRESS: 59 Greene St Cumberland — DATE SIGNED: 11/26/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Nov 27, 1950
NAME OF CEMETERY OR CREMATORY: St. Peter & Paul
LOCATION (City, town, or county): Cumberland, (State): Maryland

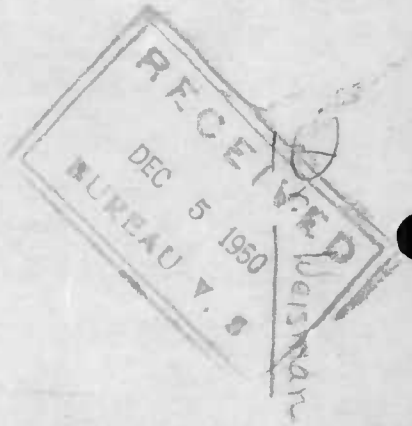
DATE REC'D BY LOCAL REG.: Nov. 27, 1950
REGISTRAR'S SIGNATURE: Walter R. Fantz M.D.
24. FUNERAL DIRECTOR: Louis Stein Inc. — ADDRESS: Cumberland

15677

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15


RECEIVED
DEC 5 1950
BUREAU V. S.

Within corporate limits

Fr. F. Wm

10873

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Kight 1454

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 46 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE PENNSYLVANIA COUNTY SOMERSET
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BERLIN
STREET ADDRESS (If rural, give location) 509 NORTH ST.

3. NAME OF DECEASED (Type or Print) (First) MARGARET (Middle) (Last) SWARTZENDRUBER

4. DATE OF DEATH (Month) NOV. (Day) 12 (Year) 1950

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH FEBRUARY 3 1871
9. AGE last birthday 79 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME SAMUEL FORNEY
14. MOTHER'S MAIDEN NAME SCHROCK (ELIZABETH)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS MEMORIAL HOSPITAL*CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of ?

141X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) tongue

45b (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-17, 1950, to 11-12, 1950, that I last saw the deceased alive on 11-11-, 1950, and that death occurred at 3:50 Am., from the causes and on the date stated above.

SIGNATURE: N. F. Williams (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED 11-13-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 14 Nov. 1950
NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery, Berlin, Pa.
LOCATION (City, town, or county) Berlin, (State) Pa.

DATE REC'D BY LOCAL REG. Nov. 13, 1950
REGISTRAR'S SIGNATURE Winter A. Frantz, M.D.
24. FUNERAL DIRECTOR Johnson & Son, Berlin, Pa. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
NOV 14 1950
BUREAU V. R

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10874

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 30 Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 322 Davidson St	STREET ADDRESS (If rural, give location): 322 Davidson St

3. NAME OF DECEASED (Type or Print)	(First) Maude	(Middle)	(Last) Tewell	4. DATE OF DEATH	(Month) Nov	(Day) 7	(Year) 1950
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Sept 23 1884	9. AGE last birthday: 66 yrs.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House	10b. KIND OF BUSINESS OR INDUSTRY: House Wife	11. BIRTHPLACE (State or foreign country): Clearville Pa.	12. CITIZEN OF WHAT COUNTRY? US				
13. FATHER'S NAME: Nathan Cooper	14. MOTHER'S MAIDEN NAME: Elizabeth Wilkinson						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT AND ADDRESS: ThomasTewell Cumberland, Md.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial Failure — [illegible]

443X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive C-V Dis — Unknown

93d (c) Arteriosclerosis — Unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from April 19 51, to Death 19 ..., that I last saw the deceased alive on 11 7, 1950, and that death occurred at ... a. m., from the causes and on the date stated above.

SIGNATURE: [illegible] (Degree or title) ADDRESS: 404 Decatur St Cumb. Md. DATE SIGNED: [illegible]

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: Nov 10 1950	NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery	LOCATION (City, town, or county) (State): Chaneysville Pa.
DATE REC'D BY LOCAL REG.: Nov. 9, 1950	REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.	24. FUNERAL DIRECTOR: William H. Kight Cumberland, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
NOV 14 1900
BUREAU V. R

Evidence for addition in 21 shown on:

10875

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

FILM No. G 12 NOV 27 1950

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place) 7 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 67 High St.; STREET ADDRESS (If rural, give location) Frostburg, Md.

3. NAME OF DECEASED (Type or Print): (First) Rita (Middle) May (Last) Valentine

4. DATE OF DEATH: (Month) 11 (Day) 14 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: Nov. 25-1945

9. AGE last birthday: 5 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Cumberland, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Eugene Valentine

14. MOTHER'S MAIDEN NAME: Eleanor M. Lonergan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: 67 High St. Eugene Valentine, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	24 hrs
903.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Spinal Bifida operation - 4½ yrs ago	
186a	(c) Fracture Femur left.	2 weeks

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

(CITY OR TOWN) (COUNTY) (STATE): 67 High St. Frostburg, Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): 11-1-50 m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR? Slipped and fell, while walking with braces on legs. (11-27-50 - ams)

22. I hereby certify that I attended the deceased from 28 Oct, 1950, to 14 Nov, 1950, that I last saw the deceased alive on 14 Nov., 1950, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

SIGNATURE: John B. Davis, (Degree or title) MD; ADDRESS: Frostburg Md; DATE SIGNED: 11/14/50.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: 11-16-1950; NAME OF CEMETERY OR CREMATORY: Frostburg Memorial; LOCATION (City, town, or county): Frostburg; (State): Md.

DATE REC'D BY LOCAL REG.: 11-16-50; REGISTRAR'S SIGNATURE: Mrs. Nancy N. Rose

24. FUNERAL DIRECTOR: Jacob Hafer; ADDRESS: Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 20 1950
BUREAU V. S

Within corporate limits

10875

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 67 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 103 Greene St

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 103 Greene St.

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Francis (Last) Webster

4. DATE OF DEATH: (Month) Nov (Day) 24 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: Sept. 28, 1883

9. AGE last birthday: 67 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Roller.

10b. KIND OF BUSINESS OR INDUSTRY: Steel Plant.

11. BIRTHPLACE (State or foreign country): Cumberland Md

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: James T. Webster

14. MOTHER'S MAIDEN NAME: Mary A. Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: James W. Webster, Cumbd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Tongue with metastasis — Interval Between Onset and Death: 6 months

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

141X 45

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 19 50 to 11-23 19 50 that I last saw the deceased alive on 11-23, 19 50, and that death occurred at 3:30 P. m., from the causes and on the date stated above.

SIGNATURE: J. Johnson Jr. (Degree or title) M.D. ADDRESS: Cumberland, Md DATE SIGNED: 11-24-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Nov 27 50 — NAME OF CEMETERY OR CREMATORY: St. Peter & Paul's Cem — LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Nov. 27, 1950 — REGISTRAR'S SIGNATURE: Walter K. Kantz, M.D.

24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland Md

19629

RECEIVED
DEC 5 1951
BUREAU P. A.

10877

Within corporate limits

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH · COUNTY: Allegany MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Alleg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 207 Union Street	STREET ADDRESS (If rural, give location): 207 Union Street

3. NAME OF DECEASED (Type or Print): (First) James (Middle) F. (Last) White

4. DATE OF DEATH: (Month) Nov. (Day) 12 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: March 14, 1874

9. AGE last birthday: 76 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Express Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Am. Railway Express

11. BIRTHPLACE (State or foreign country): New York N.Y.

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Edward White

14. MOTHER'S MAIDEN NAME: Margaret Darcy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 712-16-6314

17. INFORMANT AND ADDRESS: John F. White Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocarditis — 3Mo 12 D.

4222

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

932

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): None

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-29-, 1950, to 11-12-, 1950, that I last saw the deceased alive on 11-12-50, 19....., and that death occurred at 5:30 p.m., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title) ADDRESS: Cumberland Md. DATE SIGNED: Nov 13 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 11/16/50 — NAME OF CEMETERY OR CREMATORY: Holy Name Cem. — LOCATION (City, town, or county): Jersey City N.J. (State)

DATE REC'D BY LOCAL REG.: Nov. 14 1950 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: James F. Scarpelli Cumberland Md. ADDRESS

26648

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
NOV 21 1960
BUREAU

Within corporate limits Dr. L. Bringa

10878

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 321½ Beall St.

3. NAME OF DECEASED (Type or Print) (First) Judith (Middle) Ann (Last) White

4. DATE OF DEATH (Month) Nov. (Day) 26, (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH 11-25-1950
9. AGE last birthday yrs. If under 1 year Months 1 Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Francis White
14. MOTHER'S MAIDEN NAME Doris Messenger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Francis White Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) ~~peritonitis~~ premature bdy	~~7 days~~ 1 day
761.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) ~~Strangulated umbilical hernia~~	~~6 days~~
160 c	(c) pregnancy of 6 months duration placenta previa	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-25, 1950, to 11-26, 1950, that I last saw the deceased alive on 11-25-, 1950, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE L. Bringa (Degree or title) MD ADDRESS 57 Greene St. DATE SIGNED 11-26-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 11-27-1950
NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Nov. 27, 1950
REGISTRAR'S SIGNATURE Walter R. Frantz, M.D.
24. FUNERAL DIRECTOR Charles L. George ADDRESS Cumberland, Md.

20X250253 24V

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 5 1950
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10879

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 37 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 171 Hanover St.

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) Howarth (Last) Whitfield
4. DATE OF DEATH: (Month) Nov. (Day) 16 (Year) 1950

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (specify): Widowed
8. DATE OF BIRTH: July 188X
9. AGE last birthday: 68 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Franklin Ind.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James A. Howarth
14. MOTHER'S MAIDEN NAME: Mary Elizabeth Murray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Miss Helen Sharrette

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral arteriosclerosis — 1 Year

260X 61 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) diabetes — 10 Years
(c) arteriosclerotic heart disease — 5 Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-3, 1949 to 11-16, 1950, that I last saw the deceased alive on 11-16, 1950, and that death occurred at 8:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
[signature] MD 57 Greene St. 11-17-50

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) (State)
Burial — Nov. 20 50 — Rose Hill Cem — Cumberland — Md.

DATE REC'D BY LOCAL REG. — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR — ADDRESS
Nov. 20, 1950 — Wirtes K. Fantz, M.D. — Louis Stein, Inc. — Cumberland

RECEIVED
NOV 28 1950
BUREAU

Within corporate limits

10880

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (In this place): 15 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md.
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 632 N. Mechanic St.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) (Last) Wells

4. DATE OF DEATH: (Month) Nov. (Day) 25 (Year) 1950

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Feb. 18, 1877

9. AGE last birthday: 73 ~~74~~ yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Warden

10b. KIND OF BUSINESS OR INDUSTRY: Sylvan Retreat

11. BIRTHPLACE (State or foreign country): Midland, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Wells

14. MOTHER'S MAIDEN NAME: Eliza Care

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-03-9989

17. INFORMANT: wife) Catherine Wills, Wellersburg Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Obstruction & gangrene of the bowel due to- — about 3 days

153X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — (b) Carcinoma of the sygmoid. — ?

462 (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 11-25-50

19b. MAJOR FINDINGS OF OPERATION: Either, ruptured diverticulitis or annular carcinoma of the bowel.

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☒, *Inquiry* ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland, Md. Nov. 25-1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Nov. 28, 1950
NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
LOCATION (City, town, or county) (State): Cumberland, Maryland

DATE REC'D BY LOCAL REG.: Nov. 28, 1950
REGISTRAR'S SIGNATURE: Walter K. Manty, M.D.
24. FUNERAL DIRECTOR: William A. Light
ADDRESS: Cumberland, Md.

31692

RECEIVED
DEC 5 1950
BUREAU OF

Within corporate limits

Durrett

10881

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 3 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Williams Road
STREET ADDRESS (If rural give location) Route 2 Cumberland Rural

3. NAME OF DECEASED (Type or Print) (First) George (Middle) Oscar (Last) Wilson
4. DATE OF DEATH (Month) Nov (Day) 27 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 3/8/1880
9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY General Farming
11. BIRTHPLACE (State or foreign country) Near Cumberland Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Harvey Wilson
14. MOTHER'S MAIDEN NAME Molly Frantz
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT AND ADDRESS Mrs Geo O. Wilson, Rt 2, Cumberland Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uraemia	4 wks.
151X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 46b	(b) Scirrhus Carcinoma of Stomach	6 mon
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 15, 1950, to Nov. 27, 1950, that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE Clay E. Durrett (Degree or title) M. D. ADDRESS Cumberland DATE SIGNED 11/29/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov. 30, 1950
NAME OF CEMETERY OR CREMATORY Mt Herman Meth. Cem
LOCATION (City, town, or county) Near Cumberland (State) Md

DATE REC'D BY LOCAL REG. Nov. 29, 1950
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr Purvis

RECEIVED
DEC 5 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10882

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH- COUNTY: Allegany — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) ELEANOR	(Middle)	(Last) WOLFE	4. DATE OF DEATH	(Month) Nov. (Day) 28, (Year) 1950
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH: 11-27-1950	9. AGE last birthday: yrs.	If under 1 year: Months. Days 1 — If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Frostburg, Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME: John Wolfe	14. MOTHER'S MAIDEN NAME: Eleanor Devore				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS: John Wolfe, Frostburg, Md. RD 2			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) anoxia by respiratory failure	2 hours
773.5 Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) prematurity	1 day
159	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-27, 1950, to 11-28, 1950, that I last saw the deceased alive on 11-27, 1950, and that death occurred at 3 a. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Adolph Wolferman	M.D.	Frostburg	11-28-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 11-28-50	NAME OF CEMETERY OR CREMATORY: Fbg. Memorial Park	LOCATION (City, town, or county) (State): Frostburg, Md.
DATE REC'D BY LOCAL REG.: 11-30-50	REGISTRAR'S SIGNATURE: Mrs. Nancy N. Rae	24. FUNERAL DIRECTOR: J. R. Durst,	ADDRESS: Frostburg, Md.

20X270 393 240

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 4 1950
BUREAU V. S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

10883

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (In this place) 7 HOURS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE WEST VIRGINIA COUNTY HAMPSHIRE
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN AUGUSTA
STREET ADDRESS (If rural, give location) ROUTE # 1 ✓

3. NAME OF DECEASED (Type or Print): (First) ROBERT (Middle) T. (Last) WOLFORD
4. DATE OF DEATH: (Month) NOV. (Day) 22. (Year) 1950
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): SINGLE
8. DATE OF BIRTH: MAY 27, 1933
9. AGE last birthday: 17 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): APPLE PICKER
10b. KIND OF BUSINESS OR INDUSTRY: SUNRISE ORCHARD
11. BIRTHPLACE (State or foreign country): AUGUSTA, W.VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: CHARLES E. WOLFORD
14. MOTHER'S MAIDEN NAME: ROSIE HOTT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS: FATHER - C.E. WOLFORD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) CEREBRAL HEMORRHAGE DUE TO FRACTURED SKULL FROM AUTOMOBILE ACCIDENT IN W.VA.	8 HRS.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
823.5 1700	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY HIGHWAY
(CITY OR TOWN) (NEAR) RIDGELEY, W.VA. (COUNTY) MINERAL (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY 11/22/50 3:30PM
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? AUTO SKIDDED AND WENT OVER EMBANKMEN

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H.V.DEMING M.D. H. V. Deming M.D.
ADDRESS: CUMBERLAND, MD.
DATE SIGNED: 11/23/50

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
DATE THEREOF: 11-24-50
NAME OF CEMETERY OR CREMATORY: MALICH CEMETERY
LOCATION (City, town, or county) (State): HOY, W.VA. HAMPSHIRE

DATE REC'D BY LOCAL REG. Nov. 23, 1950
REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR: W. H. McKEE
ADDRESS: AUGUSTA, W.VA.

8600

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BUREAU V. S